A RESEARCH STUDY INTO THE EFFECT OF MIDWIFE ‘DEBRIEFING’ ON THE PSYCHOLOGICAL WELLBEING OF WOMEN AFTER BIRTH

BY

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VOLUME I

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INTRODUCTION TO THE PORTFOLIO

Volume 1
The first volume contains two essays, three problem based learning reflective accounts and summaries of two case discussion group process accounts which contribute to the academic dossier. It also contains summaries of the placements completed during training and of the five case reports written for the clinical dossier. Finally it contains the entire research dossier, which consists of a service related research project, the abstract of a qualitative research project, the major research project and the research log checklist.

Volume 2
The second volume contains two case discussion group process accounts in full which contribute to the academic dossier. It also contains the complete clinical dossier including five case reports in full and placement contracts, logbooks and evaluation forms. This volume will be held in the Psychology Department of the University of Surrey because of the confidential nature of the material it contains.

The portfolio illustrates academic, clinical and research skills acquired during training. Within each dossier work is presented chronologically to demonstrate the development of the skills.
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PART 1:

ACADEMIC DOSSIER
ADULT MENTAL HEALTH ESSAY

TO WHAT EXTENT IS MEMBERSHIP OF AN ETHNIC MINORITY GROUP (IN THE UK) INFLUENTIAL IN THE PROCESS OF DIAGNOSIS AND TREATMENT OF PSYCHOSIS?

JANUARY 2005

YEAR 1
Introduction

The essay title appears to suggest that membership of an ethnic minority group in the UK might influence how people from different ethnic backgrounds are diagnosed and treated in respect of symptoms of psychosis.

Why is this an important question to answer? The Race Relations (Amendment) Act 2000 places a responsibility on service providers to eliminate unlawful racial discrimination and promote equality of opportunity and good relations between persons of different racial groups. If membership of an ethnic minority group operates in some way as grounds for differential diagnoses and treatment then service providers are neglecting their duty to eliminate racial discrimination and promote equality under this act.

Why might members of ethnic minority groups have a different experience of mental health services to that of members of the majority ethnic group? And if this is the case what are the implications? Potentially, sub-optimal care might be provided to some members of all ethnic groups if being a member of an ethnic group influences in some way how an individual is diagnosed and treated. There are potential disadvantages for some people who might be undiagnosed or who might benefit from more coercive treatments but who are under-medicated or left un-sectioned or unrestrained in circumstances where this would be beneficial and where members of other ethnic groups would receive this treatment. Also, members of some ethnic groups may be over-diagnosed, over-medicated or restrained in circumstances where members of other ethnic groups would not and where this is not to their benefit.

What evidence is there to indicate that membership of an ethnic minority group might be influential? According to a recent study of mental health services received by African Caribbean people in the UK (The Sainsbury Centre for Mental Health, 2002) people of African Caribbean heritage are ‘massively over-represented in the most restrictive parts of mental health services’ as well as ‘in terms of negative experiences and indicators’. Indeed, an audit conducted by South West London and St Georges Mental Health NHS Trust (SWLSTG) from September to December 2002 found that approximately half of the forensic service's male patients were of African or Caribbean origin. Other criteria
that can be used to judge the influence of belonging to an ethnic minority group include length of stay as an inpatient, the number of readmissions and the use of medication. Following a review of relevant literature, Bhui, Stansfield et al. (2003) commented that ‘inequalities of service use across ethnic minority groups are important to policy makers, service providers and service users’

Definitions
The essay title appears to be quite broad, including as it does the concepts of ethnicity and psychosis as well as diagnosis and treatment. In order to enhance an understanding of the meaning and implications of the essay question it would be beneficial to start by considering the significance of the words used to construct the title.

The essay question refers to ‘membership of an ethnic minority group (in the UK)’, but what does this mean? Fernando (2003) defines ethnicity as being ‘about self-perception - how people see themselves - that takes on board the diversity of subjective positions, experience and histories of people’. So an attribution of ethnicity is subjective; when people define their own ethnicity they often take into account their cultural and racial heritage, but two people with similar cultural and racial backgrounds may not necessarily define their ethnicity in the same way. Within the UK, the majority ethnic group is ‘white; British’; representatives from many other different ethnic minority groups also reside in the UK. It is not possible to include every ethnic minority in this essay, however, to concentrate on the experiences of only one ethnic minority group might risk giving the impression that the members of all minority ethnic groups have identical experiences when this is not the case. Therefore this essay will refer to research conducted with people from a variety of ethnic minority groups whilst recognising that this will not provide a definitive explanation.

The literature reviewed for this essay has lacked consistency in the use of terminology to describe the ethnicity of people who are not white. Some studies refer to people as ‘black’, whereas others use the terms, ‘West African’ or ‘African-Caribbean’. Some studies refer to people as ‘Asian’ whereas other use the terms ‘south Asian’, ‘Indian’, ‘Pakistani’, or ‘Bangladeshi’. Some studies looked at the experience of people born in the UK and some did not specify whether this was the case or not. Also, most of the
literature reviewed for this essay allocated people to the category of 'white' without taking into account the fact that many white people, for example the Irish, are also actually members of an ethnic minority in the UK. This essay will quote the specific wording provided in the literature quoted rather than attempt to create homogeneity of terminology.

What is ‘the process of diagnosis and treatment’? According to the Collins Pocket English Dictionary (1981), 'process' is 'a method of doing something in which there are a number of steps', 'diagnosis' is 'the act or process of determining the nature of a disease, problem etc by examination and analysis; a decision based on this' and 'treatment' as the 'act, manner, method etc of treating; medical or surgical care'. How do these definitions help in understanding the essay question? What are the steps involved? Those responsible for diagnosis utilise the diagnostic criteria from DSM-IV (American Psychiatric Association, 1994) or the ICD-10 (World Health Organisation, 1994) classification of mental and behavioural disorders in order to assign a diagnosis. Where the symptoms present appear to be compatible with those required for a diagnosis of psychosis then such a diagnosis is made and treatment specified accordingly.

The term ‘psychosis’ refers to a group of disorders characterised by the distortion of thinking and perception and manifest by the experience of delusions and/or hallucinations and by negative symptoms such as flattened affect and avolition. Schizophrenia is the most common of the psychotic disorders and much of the research referred to in this essay has been conducted with people who have this diagnosis. Predisposing risk factors are genetic & early environmental hazards (i.e. intrauterine and perinatal) and precipitating risk factors include adverse life events and drug abuse, according to Aitchison et al. (1999). It is possible that the effects of adverse life events are responsible for differential rates of diagnosis of psychosis as members of some ethnic groups have experienced forced migration and asylum seeking and/or the negative effects of racism within the UK.

So, the essay title requires an analysis of how being a member of a non-white British ethnic group in the UK can influence the steps taken in determining the nature of a
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disease or problem and also the provision of medical care in respect of the occurrence of the symptoms specified for a psychotic disorder.

Having clarified the essay question, how are we to determine which factors could affect how membership of an ethnic minority group might be influential in the diagnosis and treatment of psychosis? Possible factors include the pathways used to access care, explanatory models of illness and symptoms, the role of the cultural stigma of mental illness, the cultural validity of diagnoses, institutional racism, stereotyping and prejudice, and the ethnicity of staff responsible for diagnosis and treatment; these factors will now be considered.

Pathways to care

A pathway to care is the route by which people access and utilise specialist mental health services and includes the diagnosis and treatment they receive. Bhui, Stansfield et al. (2003) conducted a systematic review of qualitative studies that investigated the use of mental health services by more than one ethnic group in the UK. Their review of 38 papers concluded that black patients are more likely to access complex or crisis pathways to care and more likely to be inpatients whether admitted voluntarily or compulsorily, compared to white patients. Bhui, Stansfield et al. (2003) noted that most of the studies they reviewed were based in London and that although the majority of the UK’s ethnic minority communities are located within the larger cities these studies did not encompass the experiences of the comparatively few members of these ethnic groups who lived in a more rural environment.

Subsequent to the review by Bhui, Stansfield et al. (2003), Bhugra et al. (2004) investigated pathways into care, citing Neighbors (1985) who found that almost a fifth of the black people in his study first sought help from a minister and Gater et al. (1991) who argued that in countries with less well resourced psychiatric services patients may use traditional healers first. Bhugra et al. (2004) studied the pathways taken by 156 white patients and 85 black patients. They found that black patients were less likely than white patients to access mental health services via primary care (56% of black patients compared to 68% of white patients) and were much more likely to be referred to services directly by the police (13% of black patients compared to 3% of white patients),
suggesting that dissatisfaction with primary care services may lead to more coercive pathways to secondary care.

What else could influence pathways to care apart from satisfaction with primary care services? In order to utilise the conventional pathway to care (accessing specialist secondary care services via primary care) the individual concerned must understand what services exist and how to access the appropriate services; prerequisites for this might include an understanding of what services are available and an adequate knowledge of the English language in order to communicate with the service. Inadequate provision of support to enable access to services and of interpreters or bilingual mental health professionals may therefore hinder members of some ethnic minority groups from accessing the care that they need.

Explanatory models of illness and symptoms

When considering the reasons why members of different ethnic groups might make contact with mental health services in different ways it is useful to identify how they explain the cause of their illness. McCabe and Priebe (2004) compared explanatory models of illness in schizophrenia in people from four ethnic groups (African-Caribbean, Bangladeshi, West African and UK White) who met the criteria for a diagnosis of schizophrenia according to DSM-IV (American Psychiatric Association, 1994); they found that whites cited a biological cause of their illness more often than any of the three ethnic minority groups. Indeed, none of the Bangladeshi group regarded their illness as having been caused by biological factors; if this finding is indicative of the Bangladeshi population as a whole it is possible that they rarely present to primary care services as such services simply do not appear to be relevant. Some members of all three ethnic minority groups in this study (but none of the UK white group) attributed the cause of their illness to the supernatural, indicating that some may prefer to consult spiritual or traditional healers first rather than primary care and so only present to mental health services when their symptoms are much more advanced.

Different cultural interpretations of the symptoms of psychosis might also mean that people with these symptoms are less likely to report them early on, thus increasing the
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likelihood of them presenting to services when their illness is more acute. Pote and Orrell (2002) investigated differences in lay perceptions of schizophrenia in different ethnic populations in Britain and found that compared to the white British group, a lower proportion of Bangladeshi participants identified ‘hallucinatory behaviour and suspiciousness’ as being symptoms of mental illness and also that those of an Afro-Caribbean cultural background were least likely to rate ‘unusual thought content’ as a symptom. When Pote and Orrell considered the religion of their participants they also found that Muslims were more likely than the non-religious and Christian groups to consider alogia as a symptom of mental illness. These findings indicate that some symptoms of schizophrenia are not viewed as such by members of some ethnic or religious groups and perhaps would not therefore be reported to primary care.

The cultural stigma of mental illness

What is the role of stigma around mental health problems within ethnic minority communities in keeping psychosis symptoms hidden, especially in the early stages?

Mind’s information sheet entitled ‘Mental Health of Chinese and Vietnamese people in Britain’ quotes Terrino Chan from the Chinese Mental Health Association as saying:

In the Chinese world, mental illness will bring a strong sense of shame. A common coping strategy is hiding from family, friends and the community. Mental health problems are kept inside the individuals and relieved by gambling, alcohol and angry outbursts. Another way of hiding is to perceive the symptoms as physical rather than psychiatric in origin. This leads to not accessing services.

In cultures where mental illness is so stigmatised the recognition of symptoms of psychosis and the accessibility of pathways to care could be compromised by the need to hide the symptoms from other members of the community.

The cultural validity of a diagnosis of psychosis

How culturally valid is a diagnosis of psychosis? As has already been shown, some ethnic groups do not recognise some of the diagnostic symptoms of psychosis as being valid. Fulford et al. (as cited in Fernando, 2003) argue that the values subscribed to by
those responsible for making a diagnoses will come from the culture within which psychiatry has developed and which reflects not only western values but also western perceptions about race and culture. How likely are members of other cultures to willingly access a pathway to care which might lead to such a diagnosis, and how likely would they be to accept such a diagnosis once it has been given?

Fernando (2003) questions how useful the term 'schizophrenia' is; he argues that 'the use of schizophrenia as a diagnosis is no longer useful in a multi-ethnic society' and that 'black people, and black communities as a whole, experience the diagnosis of schizophrenia as oppressive'.

**Institutional racism**

Could it be that the institutions involved in the diagnosis and treatment of psychosis are themselves racist? Macpherson (1999) has defined Institutional racism as:

> The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.

How can the effects of institutional racism be identified? Ethnicity monitoring provides a method of measuring how members of different ethnic groups access services and which diagnoses and treatments they receive; such monitoring requires that service users define their own ethnicity and that the information gathered is analysed in order to identify inconsistencies. If inconsistencies are identified it is possible that the processes involved are in themselves somehow racist, but also that the inconsistencies are due to a difference between the needs of the different groups considered. Another explanation might be that the people responsible for the processes are applying them in a way which involves stereotyping or prejudice.
Stereotyping and prejudice

Stereotyping is a way of simplifying the world by placing people into different categories and prejudice is 'an unjustifiable negative attitude toward a group and its individual members' which 'biases us against a person based solely on our identifying the person with a particular group', (Myers, 1996). Popular stereotypes and prejudices of different ethnic groups which might impact on a diagnosis could be that Afro-Caribbeans are likely to use cannabis, leading to an increased likelihood of a diagnosis of cannabis induced psychosis, and that people of Irish origin are likely to have alcohol dependency problems which might lead to their being misdiagnosed with an alcohol-related problem and psychosis symptoms being overlooked.

Duncan (1976) (as cited in Myers, 1996) conducted an experiment where white students observed two men having a brief argument in which one man lightly shoved the other. When it was a white man who shoved a black man 13% of observers rated the action as 'violent' but when a black man shoved a white man 73% rated the action as 'violent'. This experiment illustrates that identical actions by people of different races can be perceived differently by observers and so it is therefore possible that identical symptoms might be observed and diagnosed differently.

Myers (1996) also argues that unconscious prejudice can occur when people react to others when they meet them for the first time and their conscious attention is focused on something other than the person's race. This has implications for the diagnosis of psychosis where the diagnostician may be consciously preoccupied with eliciting details of the symptoms a person is experiencing whilst being unwittingly influenced by unconscious prejudice.

Ethnicity of staff responsible for diagnosis and treatment of psychosis

Having discussed how the ethnicity of a client might influence their diagnosis of and treatment for psychosis, this essay will now consider how the ethnicity of mental health professionals working with the client might also be a factor in their diagnosis and treatment. Psychiatrists, clinical psychologists, nurses and other mental health workers may also have prejudices from their own cultures that could influence their practice with people both from their own and from different cultures. If staff members believe (wrongly
or rightly, consciously or unconsciously) that they are vulnerable or somehow under threat how does this impact on diagnosis, or the restraint of patients or the use of drugs to sedate them? Could there be perceptions amongst members of some ethnic groups that members of some other ethnic groups are more aggressive or violent than others, or that some are more vulnerable?

At this point it would be useful to consider the ethnicity profile of two professions whose members are often responsible for the diagnosis and treatment of psychosis: psychiatry and clinical psychology. Could it be that some psychiatrists and clinical psychologists are unconsciously prejudiced? How might we identify this? Are psychiatrists any more or less likely to belong to an ethnic minority group than the population they serve? According to its website (http://www.rcpsych.ac.uk/college/equality_diversity.htm), The Royal College of Psychiatrists (RCP) is currently conducting a survey of the ethnicity of its membership; ‘almost a quarter’ of the 90% of members who have replied so far have described themselves as coming from a minority ethnic group. This compares to just under 8% of the population of the United Kingdom who identified themselves as being from a non-white ethnic group in the 2001 Census (http://www.statistics.gov.uk/cci/nugget.asp?id=455), indicating that in fact psychiatrists are more likely to be members of a minority ethnic group than the general population. However, when the ethnicity figures are broken down further it can be seen that of those RCP members who replied to the survey, 75% described themselves as 'white', 16% as 'Asian', 3% as 'black', 1% as 'Chinese', 1% as 'mixed' and 3% as 'other'. This compares to the UK population as a whole where 92% describe themselves as 'white', 4% describe themselves as 'Asian', 2% 'black', 0.4% 'Chinese', 1% as mixed and 0.4% as 'other'. As has been discussed previously, 'black' people are greatly over-represented in the more coercive parts of the mental health system, yet they are also slightly over-represented in the membership of the RCP compared to the population as a whole. Of perhaps greater interest is the fact that 'Asian' people are significantly under-represented in the mental health system but over-represented in the profession of psychiatry. This essay has already considered the stigmatisation of mental illness within some Asian communities, which leads to the interesting question of why is it that the profession of psychiatry appears to be so attractive to people of a similar background? And could it be that when Asian psychiatrists diagnose fellow Asians they are also
influenced by their cultural stigmatisation of mental illness and so less likely to make a diagnosis of psychosis?

Another professional group involved in the diagnosis and treatment of psychosis is clinical psychology. The British Psychological Society (BPS) is also currently conducting a survey of the ethnicity of its membership (personal communication, Felicity Hector, 14/01/05). Not all clinical psychologists are members of the BPS or its Division of Clinical Psychology (DCP), however ethnicity data from this group should provide an indication of how ethnically diverse this profession is. So far just under 50% of the membership of the BPS’s DCP have provided ethnicity data. 94% of respondents described themselves as white and 3% as Asian; the remaining 3% being black, Chinese, mixed or other. So, clinical psychologists appear to be less likely to belong to an ethnic minority group than psychiatrists and also slightly less likely to belong to an ethnic minority group than the general population as a whole.

These statistics on the ethnicity of psychiatrists and clinical psychologists, which indicate that the ethnicity of the membership of these professions does not mirror that of the society they serve, highlight the need for issues of ethnic diversity and especially differing cultural conceptions of mental illness to be included in training programmes for both professions in order to foster a greater understanding of factors affecting the diagnosis and treatment of psychosis in respect of ethnic minority groups.

Separate psychiatric services
Having established that membership of an ethnic minority group can influence diagnosis and treatment of psychosis, this leads to the inevitable question of whether there should be separate psychiatric services for different ethnic groups? Or should it be possible to provide accessible services which put the individual at the centre, whatever their ethnic background? According to Bhui and Sashidharan (2003), existing services ‘have difficulty retaining staff and attracting and promoting Black and ethnic minority workers, and in addressing cultural issues presented by patients’. They argue that culturally specialised services which focus on personal contact and ‘relationship building in the context of culturally congruent thinking’ are better able to engage with clients from ethnic minority backgrounds. However, they also warn of the dangers of a system that
emphasises difference, and conclude that if services are planned and delivered with a commitment to tackling institutional racism the needs of all ethnic groups should be addressed adequately.

The Sainsbury Centre for Mental Health's report on mental health services for people of ethnic minorities, entitled 'Breaking the Circles of Fear' (2002), came to a similar conclusion:

there are few pleas for culturally determined services. Instead, service users and carers repeatedly ask to be treated 'with respect and dignity' and they demand better information about services with less coercion, less reliance on medication and other physical treatments, more choice.

The report questions the validity of organising services around cultural identity and suggests inequality should be regarded as an issue of customer care that affects everyone rather than as a problem of ethnicity.

A prerequisite of culturally appropriate services is the provision of facilities to provide for different cultural requirements, for example the availability of Kosher and halal foods and facilities to observe religious requirements i.e. praying and also fasting during Ramadan whilst undergoing treatment. If these needs are not respected, what will be the impact on the recovery of the patient, how likely are they to wish to engage with services and comply with treatment, and how likely are they to return voluntarily should that become necessary?

**Choice of treatment**

In order to engage members of some ethnic minority groups in treatment it may be necessary to offer more choice in the way treatment is delivered. The stigma of going into a psychiatric hospital for treatment must be addressed; in cultures where mental illness is heavily stigmatised it may be preferable to treat people in their own homes as far as possible.
Fernando (2003) comments that clients from some collectivist cultures may prefer to have their families and communities included in discussions about their diagnosis and treatment plans as this may help provide support, however issues of confidentiality around diagnosis and treatment may actually mean that family and community members are excluded unless a specific request is made by the client.

The role of family was also highlighted by Ferns (2003) in, ‘Letting Through Light: Ealing Service Users Audit’ which recommends that family-based approaches should be expanded in working with Black and ethnic minority people as ‘several cultures give families a higher priority than in modern British cultures’. The audit recognises that families can also be a source of stress and conflict for service users.

What is currently being done to reduce or eliminate discrepancies in how people from different ethnic backgrounds benefit from mental health services?

The annual report 2003 – 2004 of the SWLSTG Race Equality Scheme identified the need to develop ethnically diverse teams. An exercise has been undertaken to identify the ethnicity breakdown of staff ‘by different directorates, grades and professional groups’. Although the ethnicity breakdown of the Trust workforce as a whole was found to be similar to that of London as a whole, it was noted that ‘most teams are ethnically diverse but some are polarised and either predominantly black or white’. This finding has led to the ‘ethnic profiling of teams’ being incorporated into the Trust’s race equality review with the intention of facilitating ethnic diversity at all levels. However, Ferns (2003) found that some respondents to a service users audit would prefer staff to come from a different ethnic background, citing concerns about confidentiality and the possible jeopardising of personal and family standing within the community.

Another finding of the SWLSTG audit was that approximately half of the forensic service’s male patients were of African or Caribbean origin, this has led to the development of a psychotherapy group for black men which was well received by clients although the issue of a the lack of black male therapists was raised as a result and is now being addressed.
SWLSTG have also introduced mandatory Cultural awareness and Anti-racism training for staff to enable them to provide a more culturally sensitive service.

An area where SWLSTG has established good practice in the provision of culturally appropriate services is with its Early Intervention Service which works with people experiencing their first episode of psychosis. This is an outreach service that enables some people to stay in their own homes thus providing an alternative to admission onto a ward as an inpatient for some people and allowing a reduced period of admission for others. When the ethnicity profile of individuals using this service was analysed it was found that 'people from Caribbean and African backgrounds were greatly 'over-represented' ... compared with the population', indicating that it is providing a valuable alternative for people from communities for who ward admission is culturally inappropriate or unacceptable.

**Conclusion**

From the evidence presented above it does appear that membership of an ethnic minority group in the UK is influential in the diagnosis and treatment of psychosis, and that many factors are involved in this. Possible factors considered by this essay have included the pathways used to access care, explanatory models of illness and symptoms, the role of the cultural stigma of mental illness, the cultural validity of diagnoses, institutional racism, stereotyping and prejudice, and the ethnicity of staff responsible for diagnosis and treatment. All of these can be seen to play a part in influencing the diagnosis and treatment of psychosis. However, it is likely that there are many other factors which are unrelated to ethnicity that could be equally influential on diagnosis and treatment; gender, age and socio-economic factors are amongst other possible influences that should also be considered.

What can be done to reduce ethnicity based inequalities? More ethnic monitoring of staff at all levels as well as clients is required to ensure diversity is incorporated within teams as far as possible. More research is required such as 'Count me in', the Mental Health Act Commission's (MHAC) proposed National Mental Health & Ethnicity Census 2005 which is mentioned on the MHAC website (http://www.mhac.org.uk/census/). The purpose of the census is to obtain and analyse data on the number of black and minority
ethnic inpatients (both informal and detained) using mental health services on 31 March 2005, as well as to emphasise to providers of mental health care the importance of accurate ethnic monitoring and to examine how such data has been used to enhance the provision of services so that they are culturally sensitive and appropriate.

Further research might also examine if there are protective factors operating within some cultures which reduce the likelihood of a diagnosis of psychosis, and a greater emphasis on the involvement by service users in understanding the pathways used to access care.
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PROFESSIONAL ISSUES ESSAY

DISCUSS THE ETHICAL DILEMMAS ARISING FROM THE NICE GUIDELINES ON EATING DISORDERS WHICH STATE THAT THE TREATMENT OF CHOICE FOR EATING DISORDERS IS COGNITIVE BEHAVIOURAL THERAPY.

JANUARY 2006

YEAR 2
Introduction

In January 2004 the National Institute for Clinical Excellence\(^1\) (NICE) issued its clinical guideline on eating disorders (NICE, 2004a). This document claims to provide evidence based guidance for the treatment of anorexia nervosa (AN), bulimia nervosa (BN) and atypical eating disorders, including binge eating disorder (BED). This essay will look at NICE clinical guidelines in general before moving on to consider eating disorders and the specific psychological treatments NICE recommend for them. The essay will conclude with a criticism of these recommendations and the contemplation of some ethical dilemmas provoked by them. Aspects of the guideline relating to physiological components of treatment such as medication and re-feeding are beyond the scope of this essay.

NICE clinical guidelines

Clinical guidelines are defined by NICE (2004b) as ‘systematically developed statements to assist practitioner and patient decisions about appropriate health care’. According to Rawlins and Culyer (2004)\(^2\), NICE guidelines are produced to advise health professionals on how to provide National Health Service (NHS) patients with ‘the highest attainable standards of care’. Rawlins and Culyer claim these guidelines are based on ‘the best available evidence’, whilst conceding that this evidence ‘may not ... be very good’ and is ‘rarely complete’. Rawlins and Culyer acknowledge that clinical effectiveness alone is insufficient to guarantee the introduction of new clinical procedures or processes as their cost effectiveness, safety and efficacy must also be considered. Andrews (1999) clarifies the difference between clinical effectiveness and efficacy, describing the former as the effect obtained ‘when applied by the average doctor to the average person who seeks treatment’, and the latter as the treatment’s potential to produce the required effect under optimal clinical conditions, as best demonstrated by randomised controlled trial (RCT) where as many variables are controlled as possible.

\(^1\) Renamed National Institute for Health and Clinical Excellence (also to be known as NICE), 1\(^{st}\) April 2005.

\(^2\) The authors wrote in their capacities as chair and previous vice chair of NICE.
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What evidence does NICE use to assess treatments? NICE (2004b) states that 'well-designed' active comparator RCTs are the most reliable way of comparing one treatment against another; evidence from such trials is prioritised over those which compare with a placebo group. Controlled observational studies are deemed less reliable still, but in the absence of other evidence may be considered on a case-by-case basis where there is a sufficiently large effect size. In the case of new treatments without adequate research data, a consensus of the opinion of clinical experts may be requested.

Apparently NICE values efficacy over clinical effectiveness when weighing the evidence for treatments, but how valid is this approach in the real world, where 'average doctors' treat 'average' people? How might participants in RCTs differ from 'average' people? In their meta-analysis of manualised psychotherapies for depression, panic and generalised anxiety disorder, Westen and Morrison (2001) found the majority of potential participants were excluded from studies: the more exclusion criteria employed, the more positive the outcome. Exclusion criteria varied within and between diagnoses and included bipolar, psychotic and organic disorders, personality disorder, co-morbid substance abuse, suicidality, past psychosocial treatment, and the presence of other Axis I or Axis II disorders. Implementation of these exclusion criteria and the subsequent exclusion of large numbers of potential participants suggest that the findings of these studies can only be generalised to around 35% of individuals presenting with the disorders investigated. However, 'average' people do present with such co-morbid conditions as well as the disorder for which they require treatment and 'average doctors' and other health professionals need guidance on how to treat the disorder in the presence of these conditions.

The evidence most valued by NICE may also be subject to publication bias. Bardy's (1998) investigation into the selective reporting of results of clinical trials found trials with a positive outcome were significantly more likely to be published than those with an inconclusive or negative outcome. Easterbrook et al. (1991), note that studies with

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3 The exclusion rates identified were 68% for depression, 65% for generalised anxiety disorder and 64% for panic.
significant results were likely to lead to a greater number of publications, and recommend caution when drawing conclusions from a review of published data. Montori et al. (2000) warn that pooling results from published studies can lead to the overestimation of the effectiveness of the intervention. NICE might base their conclusions on reports of positive outcomes in the absence of negative and inconclusive results simply because the reports of such trials remain unpublished. How might this be prevented? Bardy notes that the selective reporting of clinical trials could be avoided if trial sponsors or researchers were compelled to report all such outcomes to a regulatory authority. Alternatively, to obtain a full picture of what clinicians really do and what the outcomes really are perhaps clinicians could be required to register information including the number of clients presenting for assessment, type of treatment they are offered, whether the offer of treatment is accepted, number of sessions completed and outcome of treatment with NICE.

The NICE guidelines declare that the recommendations they make should be taken 'fully into account' when health professionals exercise their clinical judgement, but that they do not override their responsibility to make decisions appropriate to the individual. In his criticism of clinical guidelines, Hart (2002) argued that they 'can operate legally as a sword ... doctors can be criticised for not adhering to them, or as a shield to rebut criticism of inadequate treatment'. He maintains that guidelines have no automatic legal effect, and often state that they are not intended to override clinical judgement. However, failure to comply with a guideline may be seen as evidence of substandard or negligent care; Hart recommends that clinicians maintain a clear, dated paper trail for any divergence from guidelines in order to defend their decision if a complaint is made.

**Eating disorders**
Eating disorders appear to be increasingly common; West (1994) argues that this increased prominence is due partly to greater awareness of the disorders and reporting of cases, and partly to an actual increase in instances. Eating disorders are much more likely to effect women than men. In AN and BN females typically outnumber males by approximately nine to one (Gordon, 1990); most cases occur among women aged from their teens to their mid-twenties. Compared to AN and BN, BED appears to effect proportionally more men and also an older age group. Barry *et al.* (2002) found almost
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one in five clients presenting for treatment for BED were male; the mean age of the clients they studied was forty-two.

AN is characterised by a refusal to eat; sufferers typically exhibit cachexia (emaciation) (Gordon, 1990). According to the Fourth Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV) (1994) the following must be present for a diagnosis of AN. The individual must refuse to maintain their body weight at or above a minimal normal weight for their age and height and display an intense fear of gaining weight. They must exhibit a disturbance in the way they experience their body weight or shape, undue influence of body weight or shape on self-evaluation, or deny the seriousness of their current low body weight. In post-menarchal women, amenorrhea is required. AN is rare; van Hoeken et al. (2003) suggest incidence rates (number of new cases in the population) of eight per 100,000 per year. Pawluck and Gorey (1998) note AN is much more common in teenage than older women, with 51 cases per 100,000. When more carefully targeted populations are analysed, prevalence rates (the actual number of cases in the population) of 1% of girls at boarding school (Crisp and McGuiness, 1976), 3.5% of fashion students and 7.6% of professional ballet students (Garner and Garfinkel, 1980), are found according to West. It is unclear whether the elevated incident rates found in professions such as fashion and ballet are due to demands of these professions, or whether the professions attract individuals who have a predisposition to develop AN.

BN is characterised by compulsive binge-eating followed by compensatory behaviour to alleviate the threat of subsequent weight gain; bulimics tend to maintain their weight within the range normal for their age and height. For a diagnosis of BN to be made according to DSM-IV, recurrent episodes of binge eating are required, combined with a sense of lack of control over eating during episodes. Binge eating is coupled with the recurrent use of compensatory behaviour (purging by self-induced vomiting or abuse of laxatives or diuretics, or excessive exercise). Episodes of binge eating and of purging are to occur at a minimum average of twice a week for at least three months. As with AN, self-evaluation is unduly influenced by body shape and weight. A general population study by Hoek (1991) reported an incidence rate for BN of eleven per 100,000 per year. A study of female shoppers by Pope et al. (1984) found almost 5% to be bulimic;
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Beumont and Touyz (1987) claim that within a female student population rates of bulimia may be as high as 19%. Fairburn and Harrison (2003) note that individuals with BN are often reluctant to seek help; most are not in treatment and those who are often wait many years before requesting it.

DSM-IV (1994) includes a further category, eating disorders not otherwise specified (EDNOS)\(^4\), which extends the diagnosis of eating disorders to include those which do not meet the specific criteria for AN or BN. BED is an eating disorder variant included in this diagnostic category. Individuals with BED experience recurrent episodes of binge-eating over which they have a sense of lack of control, but do not engage in compensatory weight control behaviours or experience over-concern about weight and shape. Kinzl et al. (1999) found 3.3% of a community sample of women met the DSM-IV criteria for BED.

Eating disorders are regarded as multi-factorial in origin; biological, psychological, familial and socio-cultural factors may all contribute, with the relative importance of each factor varying with the individual.

**NICE treatment recommendations for eating disorders**

The NICE guideline makes the following recommendations for the treatment of eating disorders:

For AN, NICE (pp.13-16) recommend that in most cases psychological treatment is provided on an outpatient basis and should normally last for at least six months, or twelve months if it follows weight restoration as an inpatient. NICE recommend that the preference of patients (and carers where appropriate) should be considered when determining which therapy will be employed. Therapies to be considered by the clinician include cognitive analytic therapy, cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy and family interventions; the latter being particularly recommended for children and adolescents. NICE (2004c) have issued a guide for people with eating disorders and their carers which includes brief definitions of these therapies.

\(^4\) The NICE guideline uses the term ‘atypical eating disorder’ instead.
For BN, NICE (pp.16-18) recommend an 'evidence-based self-help programme' with support from healthcare professionals as a 'possible first step', followed by a course of CBT-BN, a form of CBT adapted for the treatment of people with BN. CBT-BN should consist of sixteen to twenty sessions over four to five months. NICE acknowledge that some people may not want, or may not respond to, CBT-BN and recommend other therapies be considered where this is the case; specifically IPT is recommended as an alternative.

For atypical eating disorders, NICE recommend (pp.19) that individuals are offered the treatment for the eating disorder above which most closely resembles their symptomatology. For BED they recommend an 'evidence-based self-help programme' supported by healthcare professionals, and CBT-BED, a specifically adapted form of CBT. For persistent BED, IPT for BED and modified dialectical behaviour therapy (DBT) may also be offered.

**Criticism of the NICE guidelines on eating disorders**

General criticisms of NICE guidelines have already been discussed, which may indicate that the evidence used to construct these guidelines is inadequate. The NICE guideline for eating disorders acknowledges some inadequacies in the research available for evaluation and in particular makes recommendations for 'adequately powered' efficacy studies of treatments for AN. Lack of adequate power has been seen as a specific problem with research into the treatment of AN because of the comparatively small number of cases. However, as this situation is unlikely to change NICE may have to adjust their criteria to accept and value more highly the results of qualitative studies. Efficacy studies of treatments for EDNOS, for adolescents with BN and non-responders to CBT, and effectiveness studies of the treatment of adults with BN are also suggested.

What other reasons might there be to criticise the methodology behind the NICE guidelines for the treatment of eating disorders? A good starting point is with the credentials of the Guideline Development Group (GDG). The majority appear to have a medical background and therefore may lack the specific expertise of psychologists. Indeed the individual with the title of 'lead, topic group on psychological interventions' is
not a psychologist but a professor of psychiatry. How qualified are this group of medics to evaluate and recommend psychological rather than pharmacological interventions? As the GDG contains experts in the field of eating disorders it is perhaps inevitable that some of the research evaluated was conducted by these individuals; surely there is the potential for bias in the evaluation of such evidence? Finally, with reference to the National Service Framework for Mental Health (Department of Health, 1999, pp4) principle of involving service users and carers in the planning and delivery of care, the GDG has a single patient representative but no carer representative. Given the inevitable power imbalance it is hard to see how the individual concerned could have been able to influence the decisions of the group.

Further problems lie with the research evaluated by the GDG. The use of exclusion criteria in studies has already been mentioned; the exclusion of other Axis 1 disorders is particularly relevant when evaluating treatments for eating disorders as such co-morbidity is common. Striegel-Moore et al. (2001) found that of women with BN, 13% had panic disorder and 10% major depression, and of women with BED 15% had major depression and 8% panic disorder. It is possible that the treatment NICE recommend has not been evaluated for use with around a quarter of those presenting with eating disorders due to this co-morbidity. The NICE guideline makes no reference to co-morbidity except to exclude instances where a disorder of eating is a symptom of a separate physical or other primary mental disorder (pp21).

Another problem with the research evaluated by the GDG is the exclusion of the large number of individuals who initially failed to engage in, or who drop out of, treatment for eating disorders. Waller (1997), comments that the routine omission of such data leads to the systematic distortion of ‘the picture of clinical effectiveness’ of a psychological intervention. Surgenor et al. (2004) found that one in five inpatient admissions for AN ended with the client deciding to leave ‘without clinical endorsement’, and Waller, in a study of individual CBT with women with BN or AN of bulimic subtype found 30% dropped out and 14% failed to engage. Some interventions might have a high drop out rate yet be very effective for those who remain in treatment, therefore appearing much more beneficial than is actually the case. Westen and Morrison (2001) point out that
even a relatively small dropout rate of 20% could reduce an apparent 50% success rate to 40% if dropouts were included in the denominator.

Finally, historically most eating disorders research has been conducted on young, white, middle class women as these were most likely to be affected. Increasingly a wider variety of people including men and those from diverse ethnic backgrounds have been identified as suffering from eating disorders; it is important to recognise the limitations of older research which excluded these groups and therefore cannot necessarily be generalised to them.

Ethical dilemmas arising from the NICE guidelines on eating disorders
Before considering the specific ethical dilemmas arising from the NICE guideline for the treatment of eating disorders, it will be helpful to define the term ‘ethical dilemma’. The New Shorter Oxford English Dictionary (1993, pp856), defines ‘ethic’ as ‘... the moral principles by which any particular person is guided; the rules of conduct recognised in a particular profession ...’ and ‘dilemma’ as ‘... a position of doubt ...’ pp672). An ethical dilemma can be conceptualised as a position of doubt provoked by one’s own moral principles or the rules of conduct of one’s profession. It is important to consider on whom such ethical dilemmas might have an impact? Those who may be affected include clinicians and other medical staff who attempt to implement the guideline and take decisions based on it, and the individual seeking treatment for an eating disorder and their friends, family and carers. Dilemmas might arise from the contents of the guideline but also from what is not included in it; both of these cases will be considered.

This essay has already contemplated criticisms of the methodology behind the NICE guideline on eating disorders and the GDG who produced it, and concluded that the resulting recommendations may be inadequate. An ethical dilemma might arise for a clinician in proceeding with the recommended treatments if they are aware of the limitations of the evidence upon which the recommendations are based.

As Hewitt-Taylor (2003) argues, ‘cost is an issue which cannot be ignored in the health care setting’, but whose values decide which resources are made available for the treatment of eating disorders? An ethical dilemma might arise if the values of the GDG
who developed these recommendations are not in accord with those of the individuals seeking treatment, or of the clinicians offering it. This essay has already commented on how the GDG appears unrepresentative of the client group as there is only one patient representative amongst its members; it seems likely that the values of the professionals in the group will have predominated in the decision making process. There are other reasons to question whether the values of the GDG may differ from those of the client group. Although there are slightly more women than men in the GDG they make up only 56% of the group, a far lower proportion than is found in the client group. It is impossible to tell how representative the GDG is of the client group in terms of ethnicity and social class, although it can be assumed that GDG members are on average older and more highly educated given the typical age range of people with eating disorders which has already been mentioned. Value judgements of the GDG are important as NICE use the cost per quality adjusted life year (QALY) as a measure of health outcome in order to compare treatments and make recommendations (Rawlins and Culyer, 2004). The QALY is a measure incorporating gains in life expectancy and quality of life and is inevitably influenced by social value judgements; surely more individuals with eating disorders should have been consulted regarding their quality of life and how it might be improved?

An ethical dilemma may arise for clinicians who are advised by NICE to assess people with eating disorders ‘at the earliest opportunity’ (pp.8), and if appropriate provide sixteen to twenty sessions of CBT over four to five months. Often clinicians have long waiting lists and limited resources; decisions may have to be taken about offering clients fewer sessions each in order to see more individuals, and clinicians cannot fail to be aware of the inadequacy of the treatment they are able to provide under such circumstances. In a study of the provision of psychological therapies to people with a diagnosis of schizophrenia, Pond (2005) found the provision inadequate compared to the relevant NICE guideline due largely to the insufficient availability of suitably trained clinicians and inadequate supervision. What are the implications of offering inadequate treatment for eating disorders? Crow at al.’s (1999) study of prior treatment received by patients with probable BN suggested that for many their previous treatment was inadequate; 98.6% had received some form of psychotherapy, but only 6.9% of these appeared to have received a full course of CBT, despite CBT having the most empirical
support of the therapies studied for use in the treatment of BN. From Crow et al.'s study it would appear that if insufficient treatment is provided initially clients are likely to require further treatment in the future.

Hewitt-Taylor comments that NICE guidelines are publicly available, thus providing 'a greater awareness of the options and availability of treatment'. Indeed NICE have issued 'a guide for people with eating disorders, their advocates and carers ...' which describes the different psychological treatments already mentioned in this essay and states for each disorder that 'your personal preferences should be a key factor in choosing a treatment'. How widely available is such a choice? Is this merely an illusion of choice for those who are sufficiently well informed to read the document? There is no warning that some of these therapies may not be available. An ethical dilemma may arise for the clinician; would they wish to notify a client of the existence of this document if they were unable to provide the full range of treatments covered?

Furthermore, the NICE guideline does not address the fact that eating disorders are 'notoriously difficult to treat' (Fishman, 2004, pp.17). This omission may give rise to a further ethical dilemma. In their summary of the research Mitchell et al. (2002) found that CBT can have a low success rate, with rates of abstinence from bulimic symptoms at the end of treatment ranging from 8-80% in the studies reviewed. How ethical is it to allow people with eating disorders and their carers to expect a successful outcome from treatment when so often there isn't one? The clinician may face the dilemma of whether or not to disclose such success rates to clients.

One reason eating disorders are so difficult to treat is because of the high dropout and failure to engage rates previously mentioned. It is surprising that the NICE guideline does not specifically address these issues, especially considering the existence of research into factors that might make this more likely and strategies to reduce that likelihood. Surgenor et al. (2004) found that a lower inpatient admission body mass index and diagnosis of AN purging subtype (indicating poorer impulse control) increased the risk of dropout, and that this was associated with the increased risk of relapse within one year. Waller (1997) found that non-completers perceived themselves to have more severe levels of bulimia, and were assessed as having significantly higher levels of
borderline and dissociative symptomatology, than those who completed treatment; he suggests these should be identified at initial assessment in order to focus intervention on reducing the number of non-completers. Clinton (1996) found the likelihood of eating disorder patients dropping out was related to the patient-therapist relationship, in particular a lack of congruence in their expectations of treatment; he recommends that therapists openly discuss patient's expectations and focus on any areas of discrepancy in order to limit dropout. An ethical dilemma may arise for the clinician who is aware that some clients may be harder to engage that others; do these individuals get preferential treatment initially to encourage their engagement?

An ethical dilemma may arise for the clinician if the initial treatment selected for an individual fails to work. The guidelines state, for example, that if adults with BN have not responded to CBT then IPT should be considered as an alternative psychological option. However, Mitchell et al. (2002) conducted a secondary treatment study of women with BN who failed to respond to CBT. In this study 39% were in remission from bulimic symptoms after twenty sessions of CBT over sixteen weeks and 33% were known to remain symptomatic; the later were randomly assigned to IPT or medication management for a further sixteen weeks. At the end of secondary treatment 24% of the IPT group and 19% of the medication management group were abstinent from bulimic behaviours, compared to corresponding intent to treat figures of 16% and 10% respectively. Mitchell et al. concluded that their sequential treatment approach in which complete packages of psychotherapy were administered could not be recommended, citing the high attrition rate (28% in the initial CBT intervention and a further 39% during the second intervention) and 'an unacceptable low rate of abstinence' from the secondary treatment. It would appear that such secondary treatment is unlikely to be successful although it is recommended by NICE, so should the clinician offer a secondary treatment or not?

An ethical dilemma may arise in deciding whether to treat a specific disorder at all. In their study of the natural course of BN and BED in a community-based sample over a five year period, Fairburn et al. (2000) found that of the individuals available for follow-up 'the great majority' (85%) of those originally diagnosed with BED and a 'relatively poor' 51% of those originally diagnosed with BN had made a full recovery despite not
receiving treatment. The authors acknowledged the possibility that participating in the study may have influenced outcome. A clinician may consider that the withholding of treatment from individuals with BED can be justified if 'the great majority' are likely to recover spontaneously with only monitoring similar to that used by Fairburn et al. Even, the 'relatively poor' 51% of those diagnosed with BN compares favourably with the 39% found by Mitchell et al. However, this is not a position recognised by NICE so the clinician may feel obliged to provide the treatment and utilise scarce resources unnecessarily.

The guideline can only provide a snap-shot of what is considered to be best-practice at the time it is written, but what happens if more effective treatments are identified after the guideline is issued? NICE state that a review will commence in January 2008 or sooner if 'significant evidence that affects the guideline recommendations is identified', although there would inevitably be a delay between such evidence coming to light and being evaluated, and the results of the evaluation being disseminated. An ethical dilemma might occur if a clinician became aware of such promising results of a treatment before its use was sanctioned by NICE.

The guideline warns healthcare professionals that many people with eating disorders are ambivalent about treatment; there may be an ethical dilemma involved for such professionals in deciding whether to persuade clients to remain in therapy if they do not wish to.

Another ethical dilemma posed by the NICE guideline concerns the lack of provision for new treatments to be developed within the NHS. NICE acknowledges that further research is required; given the low success rates of current treatments it may be beneficial for new treatments to be developed, but how can this happen if clinicians are restricted to using existing treatments? Will clinicians leave the NHS in order to develop new treatments in private practice, and if so how well regulated will they be?

Finally, does an ethical dilemma arise because CBT is presented by the guideline as the treatment of choice for eating disorders? As we have seen, CBT is one of five treatments suggested for the treatment of AN or EDNOS where the symptoms most
resemble AN, so this question does not apply for those disorders. For BN, BED and EDNOS where the symptoms most resemble BN, adapted forms of CBT are recommended, although IPT is also recommended for all of these disorders, and DBT is recommended for BED. If the NICE guidelines stated that CBT was the sole treatment for all the eating disorders then that would provoke an ethical dilemma, but this is not the case. Under the NICE guideline clinicians retain the right to exercise their clinical judgement and clients retain the right to express a preference regarding the treatment they are to receive.

Conclusion and reflections
From the title of this essay the reader might have assumed that the NICE guideline states that CBT is the treatment of choice for all eating disorders and/or that it is the only psychological treatment recommended. In fact this is not the case, and it is to be hoped that clinicians do not share this misapprehension. It is the responsibility of individual clinicians to ensure they have read the document thoroughly and understood its full implications.

When I began writing this essay I expected to find the guidelines to be inadequate, however now I must conclude that they do provide the best guidance currently possible. The guideline presents existing knowledge whilst recognising its limitations and respects the autonomy of clients to make choices regarding their treatment. There certainly are moral dilemmas posed by this document, but surely the most pressing is how to obtain the robust evidence needed to ensure that when the guideline is reviewed in 2008 there is more to draw on. Meanwhile, clinicians must continue making decisions about treatment which are informed by inadequate research and dealing with the ethical dilemmas that arise as a result.

Writing this essay has reminded me of the occasions when I have used NICE guidelines in the past. I recall feeling relieved that there were recommendations to follow and that I did not have to evaluate all the various treatment options myself. However in retrospect I wonder if having this work done for me meant I did not look sufficiently critically at the evidence behind the guidelines and the conclusions drawn from it? I am now more aware of the need to be critical of any guidelines, to read them thoroughly and question
their meaning and conclusions; this is only what we are taught to do when evaluating research, but writing this essay has really highlighted the importance of it for me. This in turn has led me to wonder if the guidelines have the potential to partially deskill clinical psychologists. Could there come a time when we no longer have to evaluate research, because it is all done for us by NICE? If so, how will that affect our role as scientist practitioners?

Through writing this essay I have acquired a greater appreciation of the requirement for studies to be adequately powered and the wasted opportunity of underpowered studies being unable to contribute to the evidence base. Finally, I have also achieved a greater understanding of how NICE makes decisions.
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THE RELATIONSHIP TO CHANGE:
A PROBLEM BASED LEARNING REFLECTIVE ACCOUNT

March 2005
Year 1

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This piece of work is a reflective account of my experience of being part of a Problem Based Learning (PBL) group, including how the group tackled the task we were given and my thoughts on how that process has impacted on my first four months on placement as a clinical psychologist in training.

My introduction to the concept of PBL occurred on the second day of the course. We were divided into groups, given a title, some learning outcomes and prompt questions and told to produce a presentation in six weeks time; it all seemed so vague and hard to grasp, a whole new way of learning. I was good at learning the way I did for my undergraduate degree, I knew about going to lectures, reading books and writing essays but this was so different. The title was 'the relationship to change', but what did that mean? It didn't sound like a question that required an answer. I felt disappointed that the first thing we were given to do on the course was so intangible. It all felt so unsafe, with no examples of work from previous cohorts to read for inspiration, no buddy to ask, and my trainee colleagues in various states of anxiety and confusion. The group’s facilitator was also new to the concept of PBL; it seemed that we were to learn alongside him rather than be led by him, which only served to magnify my feeling of anxiety as all I wanted was someone to tell me what to do.

In those early days at the beginning of the course there was something very comforting about being part of a small group and having the opportunity to get to know each other. My group was pulled together by the confusion generated by the task we were set and a shared desire to make sense of it; almost immediately the group members were very co-operative and mutually supportive. Everyone appeared to respect each other’s feelings and ideas and we all tried to make a special contribution to the presentation, for example by making props or arranging the rehearsals. Perhaps it was that shared early experience on the course that led us to become such a close group. I know, like and trust my fellow PBL members more than any of the other trainees.

The group developed a circle of change model and some of us invested a lot of time and thought in this, although I found myself surprisingly reluctant to get as involved as the others. Then our facilitator appeared to question our approach, which was very hard for some group members to cope with; there was anger, annoyance and hostility towards
the facilitator and stubbornness about changing. Perhaps it was because they felt insecure and so were clinging to what they wanted to be the right way to continue which made them so reluctant to let go of the model. Being 'right' was very important to some of the group; I observed their difficulty in tolerating this uncertainty and was surprised by this. My own, more detached, view was there could not possibly be a single 'right' answer to the task. Some group members found it easier than others to remain hopeful that we could resolve this task and between us we struggled on.

At times I felt very much part of the PBL Group but at other times I reverted to my usual feeling of being an outsider. Typically I am more aware of the things about me that are different from others than the things we have in common, and judge myself negatively as a result. So in my PBL group I see myself as being the only mum, much older, and lacking in clinical experience compared to the rest, even though these things should mean that I have a unique and valuable perspective. I only really feel part of the group when I have made a contribution that has been accepted and valued by the others, such as when I suggested we role play some of the changes which had happened within our group for our presentation. It was a challenge for me to make this suggestion as I lack the confidence to express my opinions and I'm never quite sure when is the right time to make a comment. What if I interrupt someone, or am ignored? What will the others think about what I have said and what will they think about me for having said it? I felt particularly vulnerable to criticism from the group as my idea meant that the focus of the presentation would shift away from the circle of change model and onto us as group members experiencing change. It was such a relief that my suggestion was heard, appreciated and accepted by the others.

Our presentation went well, but it felt unsettling to be judged when we didn't know what the criteria were. Although the marks we received were almost exclusively 'excellent/very good' I wanted to know how we had done compared to the other groups and was concerned about the two items for which we were marked as 'good/satisfactory' or 'requires revision' by one evaluator. Looking back I feel that we did really well but at the time those marks knocked my fragile confidence. I was feeling vulnerable as I had been part of something so unfamiliar and it was somehow even more important to do
well. Now I am really pleased with the marks we achieved and regard them as a testament to how well the group worked together.

I was surprised when we were asked to self-evaluate; we should probably have been doing this as we went along but were so busy trying to get things done, it didn't occur to me to keep on checking if we were doing the 'right' thing. Would our presentation have been better if we had been constructively criticising it throughout the process? Or would we have become paralysed by self-doubt and unable to do anything? It was probably most effective on this occasion for the group to proceed in the way it did but in future I hope we will be more questioning about what we are doing, perhaps by adopting a reflective team format to comment on the discussions of the main group.

In retrospect my reluctance to fully engage with the task was highlighted by the fact that I did not throw myself wholeheartedly into it and had actually felt rather disconnected from the whole process. At the time I felt overwhelmed with the new challenges of being on the course, including the long hours I was spending on the train (which I had planned to use to think but actually used to sleep) and the mind-numbing intensity of that first six-week teaching block. I felt there was no space in my head to absorb or reflect on what was happening to me. Looking back I see that I should have found a way to make the space required. I was so used to being fully occupied running my home and looking after my child and husband when I was not at work; my previous jobs had been absorbing but did not require more of me than the actual hours I worked. My family and I are still adjusting to the changes in our lifestyle and my new focus on training to become a clinical psychologist. I am so used to putting their needs before my own but this has to change if I am to survive and complete this course. Now I am determined to establish appropriate boundaries; I know there will be times when I have to be ruthless with my time and attention and that my family will have to become more self-sufficient. But how will I feel if/when they do? I will suddenly become less essential to them and will have to deal with my feelings about this change in status when it occurs.

As I write this reflective account I am searching myself to identify the changes that must have occurred in me as part of the process of this PBL exercise, but can I find them? Am I being resistant to change in myself? Is it too much for me to accept that there was
something in me that needed to be changed and that it did change? Or have I just not changed at all? What if I can’t identify any changes? Does this mean that I am incapable of reflection and will not become a good clinical psychologist? Or is it just that I have not gained any significant insights from this particular task?

I have noticed myself feeling more anxious than usual about other aspects of my life as I have struggled to write this account, it is almost as if the anxiety has contaminated other parts of my life. The struggle to reflect leaves me uncertain, it provokes my feelings of insecurity and low self-esteem, which I usually try to ignore but have to confront when I look critically at myself. I had thought of reflection as being something that happened automatically without it having to be made to happen, although as Jasper (2003) comments ‘fundamental to the concept of reflective practice is that we consciously or knowingly consider our experiences’, I had not appreciated that reflection was such an active state of mind. Furthermore, Bennett-Levy et al. (2001) comment that ‘self-reflective work seems to need a minimum requirement of time and absorption, which periods of high stress do not allow’. In retrospect I have not allowed enough time for the absorption to occur and so I should not be surprised that reflection is so hard.

Having gone through the PBL process and reflected as much as I can for this account, is there anything I have done or will do differently as a result?

I did find working co-operatively in a small group useful, which led me to convene a small group of trainees to brainstorm ideas around this PBL exercise.

My realisation of the need for effective boundaries in my home-life has reinforced the importance of these professionally too. I do find it hard to say ‘no’ to people I care about and often give too much of myself to my family which leaves me with insufficient time and space for myself. This may also mean I have a tendency to give too much to my clients for example by letting sessions overrun, which then puts me under pressure with the rest of my work. As a result of this realisation I have become more rigorous with time boundaries when working with clients.
Taking part in this PBL exercise has made me think about how clients may feel alone and confused at times and wish the therapist would provide the answer to their problems. I hope that the support I strive to provide for my clients feels more tangible to them than the support I received from the PBL group facilitator felt to me, although it may be just that intangibility which is needed to help clients think for themselves and make their own decisions.

When I started my training I was so excited, amazed that I had been selected to be on the course and thrilled at the prospect of indulging my passion for psychology for the next three years. Upon reflection I had not really thought about the specific demands the course would make on me apart from that it would be challenging. Now I am very conscious of the importance of looking after my own needs and balancing the demands of the rest of my life, and believe this new awareness will help me to become a better trainee and thus eventually a better clinical psychologist.
REFERENCES


CHILD PROTECTION, DOMESTIC VIOLENCE, PARENTING AND LEARNING DISABILITIES:
A PROBLEM BASED LEARNING REFLECTIVE ACCOUNT

March 2006
Year 2
Academic Dossier: Problem Based Learning Reflective Account 2

This work is a reflective account of my third experience of a Problem Based Learning (PBL) exercise. I found this experience less challenging than previous exercises because I was already familiar with the PBL process and the members of my PBL group. However, some of the content of the exercise was unfamiliar as when it began I had had no contact with people with learning disabilities, although I had received teaching on people with learning disabilities, systemic theory, families and child protection. The exercise provided me with the opportunity to integrate and consolidate this teaching by working on a hypothetical example, whilst simultaneously commencing my people with learning disabilities placement and meeting people with learning disabilities for the first time.

Having worked together on previous PBL tasks and as a case discussion group, the group had become cohesive and individual roles were established. When we convened for the first session of this exercise we had a new facilitator; she appeared hesitant as she joined the group and reluctant to participate in our discussions. Initially we proceeded with the task without much reference to her despite people with learning disabilities being her area of expertise; she may have expected to be asked to share her knowledge with us and to be treated as a valuable member of our group rather than an onlooker. In retrospect I wonder why we did not immediately defer to her. I recall feeling extremely anxious at the prospect of working with people with learning disabilities, especially around how to communicate with them; I may have been scared of the knowledge she had to impart, maybe the other group members were too. Perhaps by not taking advantage of her experience, we left our facilitator feeling unvalued or deskilled. This led me to consider how I as a clinician, might feel when working with groups or families who don't want or don't think they need help from outsiders, and how I could make it easier for them to recognise the benefits of psychological intervention.

Despite roles in the group having already become established I was determined to challenge myself this time. Previously I had regarded myself as a passive follower and so resolved to take the role of Chair; by formally adopting this role I hoped to find it easier to be proactive and assertive in the group. My concern was whether the rest of the group would support this change; I was relieved when they all agreed. However, occasionally I still thought I needed to remind myself and the others of my role and
would start sentences by saying 'as Chair I ...'. I believed that I could only perform this role because the others acquiesced and that they could take over whenever they wished. Sometimes I realised I wasn't leading but following them and became frustrated at my lack of assertion. I became anxious as the other group members appeared unmotivated by our task, felt it was my responsibility to focus and inspire the group, and despaired when I was unable to do so. I found the role of Chair challenging but despite this I persevered and learned that it was possible for me to take the lead in the group.

We were given a scenario based around the future of the three year-old twins of Mrs Stride, who was described as having 'learning disabilities in the mild range' and Mr Stride, who had attended a school for children with special educational needs, along with a genogram and diagram of the network of professionals surrounding the family.

The Local Authority considered the twins to be at risk of emotional abuse and neglect and had placed them in short-term foster care pending the result of a child protection case conference. Mr and Mrs Stride were 'passionate in their commitment to have the children returned to their care'. Our task was to consider whose problem this situation was and why, and to illustrate our conclusions in a presentation. We had five weeks to research and plan the presentation, during which we had three scheduled, facilitated sessions; we also met for three unfacilitated sessions.

Almost immediately the group became stuck, perhaps we were overwhelmed by the hopelessness and complexity of the scenario we had been given; maybe the parents would have felt similarly overwhelmed. I found the scenario very distressing to work with and recall telling the rest of the group this and them hardly responding, which made me think it affected only myself. I wondered if this might be because I am the only mother in the group and so was more sensitive to the idea of children being removed from their parents. However, upon reflection I question how likely it is that none of the five other members of my group were disturbed by the content of our task; perhaps they were defending against their feelings by not acknowledging them. Throughout the exercise I thought of myself as the most motivated member of the group, possibly because by acknowledging my distress I was able to put it to one side and concentrate on the task. This reflection leads me to consider how some clinicians may find it easier to work on

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See Appendix I
upsetting cases by denying their emotions about them but by doing this they may not be able to work so effectively, which has implications for my future clinical practice. As a trainee I will endeavour to discuss my feelings of distress about a case with my supervisor, and in the future as a supervisor I hope I will encourage my supervisees to do the same.

Initially we decided we would each research a different area relevant to the scenario, investigating the impact of adoption, post-natal and maternal depression, poverty, domestic violence and being raised by learning disabled parents on the wellbeing of children. We then considered the roles of the different professionals involved in the case and decided that our presentation would take the form of a hearing in the family court to determine the future of the children. It seemed unlikely that the parents could represent themselves adequately in such a setting due to their inexperience, their learning disabilities and the inherent power imbalance; we therefore created an advocate to speak at the hearing on their behalf.

Other members of the group were ambivalent regarding what decision the court should make, although it seemed clear to me that removing the children from their parents would be in their best interest. I thought this not just because the parents had a learning disability but because of that in combination with the host of complicating risk factors in the scenario, including 'deep' poverty, the witnessing of domestic abuse, maternal depression, and the apparent absence of a supportive system around the family. Perhaps I found it easier to focus on the wellbeing of the twins rather than their parents as I frequently consider that of my own child above my own. We proposed to avoid presenting a group consensus decision by asking our audience to vote on the outcome at the end of the hearing. Like so many aspects of clinical training, preparing the presentation felt rushed. I felt resentment because it took time we could have used to explore the material and the issues raised by it in greater depth. Other members of the group described similar feelings and we chose to finish our presentation with this constructive criticism of the exercise and reflections on our experience of it.

Although we had hoped to avoid making a decision about the case ourselves, at the end we were asked for our own opinion. I was astonished when every group member
declared the twins should not be returned to their parents, a conclusion in accordance with my own but opposite to that reached by our audience. Reflecting upon this I wonder if the strength of my opinion had affected the rest of the group; if I as a mother could recommend the children be removed from their parents then perhaps they thought it must be the right thing to do.

Our presentation was well received by the audience. Both tutor and peer feedback was mostly very positive and I have found this useful when considering the strengths and weaknesses of our approach. Strengths of our presentation included our use of multiple perspectives and the way we placed the parents at its centre by appointing an advocate to speak for them. A weakness might be an insufficient emphasis on the potential disadvantages of placing the children for adoption.

As a consequence of participating in this PBL exercise I have sought opportunities on my learning disability placement to discuss issues around parenting with colleagues and thus increase my understanding of this area. I have been fortunate to have had a systemically orientated supervisor; working with her has helped me think differently about the Stride's case. My placement supervisor previously worked in a geographical area with a large Bangladeshi population, where apparently learning disabled parents often received sufficient parenting support from members of their extended family and the wider community so it was rarely deemed necessary to remove their children. This knowledge led me to reflect upon the cultural context in which the PBL took place and how much influence culture might have on the outcome for parents and children in such a situation. There was little support available to the Strides from their immediate family; perhaps our group did not think of involving their extended family or the wider community because we are predominantly a white western European group and so do not come from a collectivist culture where this might be more likely. Reflecting on this led me to consider how uni-cultural staff teams may also neglect opportunities to involve extended family and other members of the community in supporting such families.

Reflecting on my initial thoughts about the Stride's scenario I am struck by how my placement experience has influenced me. For example, now I have met and worked with people with learning disability I regret the uncritical approach I took to statements about
the abilities of the parents. I am now aware that the labelling of Mrs Stride as having ‘learning disabilities in the mild range’ and Mr Stride as having attended a school for children with special needs tells us nothing of their potential to overcome some of their difficulties and become good enough parents to the twins. I have acquired an awareness of the impact poverty and the limited resources available to services can have on the lives of people with learning disability. Valuing People (Department of Health, 2001, pp.23) states that people with learning disability have the civil right to have a family, however this cannot become a reality for many unless adequate resources are provided.

Were sufficient funds available to provide ongoing parenting support (perhaps even a nanny) and household appliances for the Strides it would help them greatly to raise their twins. I am angry that people with learning disability can be deprived of the right to parenthood simply because the financial cost involved in supporting them to parent is deemed too great. In cases such as the Strides, decisions made are not necessarily about the best interests of the children but rather the allocation of resources. Does our society really place so little value on the right of people with learning disability to parent that they are deemed not to warrant the expenditure?

Finally, I have reflected on my opinion that the twins would be better off if removed from their parents and realise that I did not appreciate how strongly the children of learning disabled parents can value their relationships with their parents. However, Booth and Booth’s (2000) interviews with the adult children of learning disabled parents, revealed that most remembered ‘their family life as a child’ as ‘generally happy’ and maintained ‘valued relationships’ with their family. Reading this paper has provoked me to re-evaluate my assumptions around the experience of being raised by a learning disabled parent.
REFERENCES


APPENDIX I

Child Protection, Domestic Violence, Parenting and Learning Disabilities

The Family

The Stride Family

Live locally
Supportive

Raised in the care system
Mrs S

Mr S

Twins

Sally

Sarah

No contact with mother and father

The Professional network

= Domestic Violence
The Problem
The twins, Sally and Sarah Stride, were placed in short term foster care, following a recommendation of a full child protection case conference, and enacted at an initial Court hearing, that the children continued to be at risk in the care of their parents. The children were on the child protection register, under the categories of emotional abuse and neglect. The children’s Guardian has approached you, and asked you to help the Court by conducting a full risk assessment, and if appropriate, to help the Court develop a rehabilitation plan for the children. This is a joint instruction by all parties to the proceedings. However the Local Authority wishes to place the children for adoption, before it is too late, in the belief that Mr and Mrs Stride will never be able to care adequately for their children. Mr and Mrs Stride are passionate in their commitment to have the children returned to their care.

Whose problem is it? Why?

Some Background Information……..
Mr and Mrs Stride are white English. They live on State benefits. Mrs Stride is described as a woman with learning disabilities, in the mild range. Mr Stride attended a school for children with special educational needs. Mr and Mrs Stride do not read and write English. It should be noted that many long reports have been written about them, their children, their care of their children and so on. Their solicitors read the reports out loud to them, usually once, and sometimes on the morning of a Court hearing.

Mrs Stride has two older children living with separate adoptive families. She is not able to have contact with them at the moment, as it was a closed adoption. This is because her first husband was extremely violent to her, and threatened violence to the previous social workers. Social Services staff feared for the safety of the adopters if their whereabouts were known. Mrs Stride promised herself it would be different with this marriage and for these children.

Mr Stride has physically assaulted Mrs Stride, during disagreements. She minimises his behaviour, saying it is nothing compared to what her previous husband used to do to her. The two children have witnessed these arguments and assaults.

Mr Stride’s parents are supportive. They buy clothes and toys for the children, and occasionally buy food shopping for the family. Apparently, they are unable to look after the children, because Mr Stride’s mother suffers from a painful rheumatic condition. Mrs Stride was raised in the Looked After Children system, and has no contact with her family of origin.
Mr and Mrs Stride live in conditions of deep poverty. They do not have many household appliances that work, and it seems that Mrs Stride struggles to understand the workings of the second-hand appliances donated to them by family. It would seem that Mr Stride understands their workings, but is not prepared to use them. Social Services staff are most concerned about physical neglect of the children’s needs. Family Centre staff say they have tried to engage both Mr and Mrs Stride in parenting classes, but the couple do not attend on a regular basis. The Family Centre appointed a family worker to visit the home, and show Mrs Stride ‘how to keep house’. The family support worker has not been trained to work with parents with learning disabilities. The Social Worker says the Department has offered the family everything, and it makes no difference to the care of the children.

Mr and Mrs Stride are desperate about the loss of their children. They want them to come home. They fiercely resent the foster carers and the supervisor of their contact with the children. The children’s Guardian believes the parents can learn to be ‘good enough’ to satisfy Social Services requirements. Mrs Stride was referred to the local AMH service for help with feelings of despair and depression. She is taking anti-depressant medication, and is seeing a CPN for counselling.

Prompt Questions

......something about paying attention to the professional network (liaison, communication, respective roles)
......something about safety, risk assessment and risk management
......something about parenting and LD
......something about child witnesses to domestic violence
......something about the effects of poverty and class discrimination
......something about literacy and verbal comprehension (effects of anxiety and stress on memory and comprehension, and willingness/ability to express concerns, and say, ‘I don’t understand these reports’)
......something about resilience, adversity, depression and coping
......something about the role of grandparents in the care of children
......something about children of parents with learning disabilities
......something about gender issues and scripts
......something about psychologists, child protection and the legal system

How would you address things differently if this family were black, or if the parents were both of the same sex, or if the family came from a middle class background or if they were of average intelligence?
WORKING WITH OLDER PEOPLE:
A PROBLEM BASED LEARNING REFLECTIVE ACCOUNT

February 2007
Year 3

56
This work is a reflective account of my fourth experience of a Problem Based Learning (PBL) exercise. In some ways I have found this experience to be the most challenging of all the PBL exercises we have undertaken, despite being familiar with the PBL process and working with the other group members, and having received relevant teaching from the older people module and on diversity. The exercise took place at the beginning of the third year of my training to be a clinical psychologist and coincided with the start of my older people placement. I was therefore able to consider some of the issues raised by the exercise whilst on placement and bring some experiences from placement to my thinking about the PBL exercise.

When we began this exercise the group had already been in existence for two years. During this time we have operated as a PBL group, a Case Discussion Group (CDG), a social support group and a friendship group. The group has evolved professionally and socially, and at times it has been hard to separate these aspects. The group had had two previous facilitators who facilitated us in both PBL and CDG for a year each. When we met as a group for the first time as third year trainees we were joined by our third and final facilitator. Two trainees were on holiday and so missed this initial meeting. As at the start of the previous year there was some confusion amongst the group as to whether this first meeting was a CDG or PBL session. The PBL exercise had been emailed to us a few hours prior to our meeting but the timetable described the session as CDG. Some group members were irritated by this confusion and it took a while for the group to settle to the task in hand; eventually we read through the PBL scenario together. After this we had one other timetabled facilitated PBL session; we also met together on four other occasions.

The scenario we were given concerned Mr Khan and his family, and contained some background information and prompt questions (see Appendix I). Mr Khan was in his seventies and originally from Pakistan, his wife had recently died. Mr Khan had two daughters, one lived in Pakistan and the other in England; one daughter was concerned that he was suffering from short term memory problems. We were to work together to produce a 20 minute presentation nine weeks later, without guidance as to what that presentation should contain.
When I first read the task I recall feeling inspired by it; I have a long standing interest in diversity, lifespan and trans-generational issues and was excited at the prospect of investigating an aspect of this in greater depth. I also remember feeling angry about inconsistencies in the document we were given, such as the names of Mr Khan's daughters and who lived in which country. My immediate thoughts were that this must reflect how families from minority ethnic backgrounds are actually represented at times, and how excluded, misunderstood or disrespected this might make them feel. I also recalled having been confused by inconsistencies and lack of clarity in previous PBL exercises too. However, now that I have read Sluijsmans et al. (2001; pp.153), whose description of PBL refers to solving ‘new, complex and ill-structured real-life problems', I realise that such inconsistencies and lack of clarity might in fact have been deliberate, and dealing with them perhaps an integral part of the exercise.

As in previous PBL exercises the group decided we would each research a different topic relevant to the scenario. Following a session to generate ideas we chose to locate Mr Khan in Tooting, a multi-cultural area of south west London familiar to us, and his daughter Maya in a rural village in Pakistan. We would investigate the mental health services available for older people in both of these areas in order to consider where Mr Khan's needs would be best met. We also decided to investigate the diagnosis of dementia, Islamic beliefs and rituals around death, the effect of migration on mental health, and the provision of culturally relevant services in the UK.

Having conducted our research we met to share our knowledge and determine the format of our presentation. We decided to challenge stereotypes regarding the extent of support available to members of ethnic minorities from community and family networks (Hubert, 2004) by presenting a role play in which Mr Khan's daughters argued about whose responsibility his welfare was. This was supported by a didactic presentation which included information on the services available in rural Pakistan and in Tooting. The presentation ended with Mr Khan demanding to know why he was not included in the decision making process, as a reminder of the importance of consulting service users about their opinions. In previous PBL presentations we have included our
Academic Dossier: Problem Based Learning Reflective Account 3

reflections on the task and the process; I am unsure why we did not do so on this occasion as I consider it to have been a major strength.

Another difference to our previous PBL exercises was that no group chair was appointed this time, so nobody had the formal responsibility of keeping the group 'on task' as we worked together to produce our presentation. Consequently I think we worked together less effectively, and I am now more aware of the value of allocating roles and responsibilities when working as a team. Contributions made by members of the group were more variable this time, as individuals struggled with juggling the demands of other aspects of the course and difficult personal situations. At times I felt very much on my own in the group, it seemed that the others did not share my priorities, and our differing priorities made it harder to work together than previously. Some group members expressed frustration at being given yet another PBL task; I recall saying that as the task was compulsory we should make the most of our final opportunity to work together in this way, and try to get as much as possible from the process even if some thought it pointless. Ultimately I was unable to inspire my colleagues; I wonder if there was anything I could have done differently which would have motivated them, and not left me feeling disappointed that they did not share my enthusiasm? I found it difficult to relax and not get stressed that the presentation would be poor, but eventually came to recognise that the success of our presentation was not just my responsibility. This experience led me to realise that as a qualified clinical psychologist in the future there may be times when I will have to find a way to maintain my enthusiasm for a project or activity when working in a team with colleagues who have other priorities, and to accept an end result that is less than ideal.

Although I thought our presentation could have been better the written feedback we received afterwards was mostly complementary. I was particularly pleased with one comment, that the presentation had brought new information into our peers' knowledge base, as I felt this recognised the originality of our work. However, in some ways the presentation is the least important part of the exercise as it does not necessarily reflect the learning and cooperation that has taken place in order to prepare for it. So how else could PBL be evaluated? Sluijsmans et al. (2001) comment that peer assessment, where peers evaluate each others performance within the group, encourages individuals
to consider their peers' contributions as well as their own. Perhaps this might also encourage individuals to consider whether their own contribution is adequate? However, as Sluijsmans et al. also point out, such ratings can be affected by influences such as friendships or relationship difficulties within the group and may therefore not be unbiased.

Upon rereading my two previous PBL reflective accounts I was surprised and pleased to realise how much I have developed as a member of this group since the course began. Whereas initially I had been reluctant to express my views and happy to follow the lead of other, more assertive, members of the group, this time I think I have been able to be assertive too. However perhaps I have also done more work and taken on more responsibility than would be ideal. I think I have consistently worked well as a member of this group throughout our time together and regard my team working ability as a personal strength.

I am intrigued to know what my colleagues thought of the role I played this time; I wonder if they appreciated what I did, or whether they were just irritated by me trying to arrange times for us to meet etc. when they had other priorities. Unfortunately I will probably never know their thoughts because if I were to enquire about this I would feel I had to share my own views with them. I realise I would feel uncomfortable telling the group I was disappointed that we were not able to work together on this PBL exercise as well as we had done in the past. So although I have progressed in some ways I am also now aware that I find the prospect of giving negative feedback to colleagues difficult. This is something I will try to keep in mind as there will probably be times in my professional life when it will be necessary for me to do this.

On reflection I am aware that as a group we seem to work best as a CDG and less well at PBL, perhaps because most group members find case discussion more relevant to our work on placement and our personal development as psychologists. I have come to understand that maybe it is because I have experienced us working so well on other occasions that I felt disappointed this time.
The fact that PBL seems to have suited me better than my group colleagues has reminded me of some differences between me and them about which I was very aware in the first year, but which seemed less apparent last year. As Taylor and Burgess (1997; pp.103) comment ‘there are some elements of the [PBL] approach that make it particularly relevant for non-traditional learners’. I am the only one in my PBL group who did not come into clinical training via the traditional route. Whereas the others had been assistant psychologists and started the course in their mid-twenties, I had another career first and began the course in my early forties. Maybe this is why we have valued the experience differently.

Over the last three years I have found the PBL experience to be frustrating at times. However overall it has provided a stimulating opportunity to think about issues in depth and discuss ideas with group colleagues in order to reach a consensus on what would be presented. Watching the presentations of the other groups and seeing how they have tackled the same problem has provided an opportunity to consider yet more perspectives. I recall that in the first exercise all the presentations were fairly similar but as the course has progressed groups have become more confident and creative, so that in the final exercise there was much greater variety in the way the problem was approached. Perhaps the most important thing I have learned from PBL is to think more creatively when working with clients and consider a wider range of issues when formulating; I have been able to use this in my current placement, and my understanding of the clients I work with has been enriched as a consequence.

As I conclude this reflective account I am aware that I have not commented on the role of the facilitator in this task. With so little facilitated time I remain unsure of what impact she had on the group, other than to just let us get on with it. Perhaps because this is all we needed for this final exercise.
REFERENCES

Hubert, J. (2004). Services for people with learning disabilities from black and minority ethnic groups: a qualitative study of 30 families in a south London borough. St George’s Hospital Medical School.


APPENDIX 1

Pakistan

Mr Khan
Speaks English + Urdu
Retired bus driver

Arrived in UK
When 25

Arranged marriage

Live in Pakistan

72

65

Died of cancer 9 months ago

Home-maker and part time dressmaker

European

Journalist

40

Shamila
University (Journalist)

International correspondent
‘disowned’ daughter
Lives in the UK

42

Maya
Home-maker

45

Shopkeeper
Speaks Urdu

Arranged marriage

18

Imran
About to come to UK to study

16

14

Pakistan
Title: Working with Older People

Problem Based Learning Exercise

The Problem

Mr. Khan’s youngest daughter, Maya has contacted Social Services about her father’s health. She is concerned about her father who has been suffering from short-term memory problems. He has been leaving the kettle on and saucepans on the stove to boil dry. He has been neglecting himself and his physical health is deteriorating. He has lost some weight and he has been eating out-of-date food.

Maya, the youngest daughter is urging Social Services to do something and also asking her older sister, Shazia to return from Pakistan to help sort out a solution for their father’s care.

Some Background Information

Mr. Khan is 72 years old. He migrated to the UK from Pakistan in his mid 30’s. He is a retired bus driver. He learned English after coming to the UK.

His wife died of cancer 9 months ago. Mrs Khan did not speak English and spoke only Urdu. She was primarily a home maker, working occasionally as a private dress maker.

Mr & Mrs. Khan have 2 daughters Shazia and Maya. Both daughters were born in the UK and have had English education. The eldest daughter, Shazia had an arranged marriage in Pakistan where she lives with her family. Her husband is a shop-keeper. They have 3 children. Shazia’s eldest son Imran is currently contemplating coming to the UK to University.

Maya, the younger daughter married a European and was disowned by the family. She had no contact with her father till her mother passed away 9 months ago. Maya and her husband have no children. She is University educated. She and her husband are both journalists and fairly mobile, travelling 3-4 days a week throughout Europe and sometimes at short notice.

Mr and Mrs Khan were both religious and had links with the Muslim community. However, Mr Khan fell out with the mosque about they way they responded to his wife’s death. He has stopped going to the local Mosque but continues to pray at home.

Prompt Questions

...something about who speaks English, who speaks Urdu and who speaks both?
...something about the rift with the community in the Mosque and the potential for mediation?
...something about understanding religious faith and appropriate culturally sensitive solutions?
...something about grief and mourning – individual, family and community based?
...something about impact of migration and loyalties to country of origin and host country?
...something about the possibility of going back to country of origin?
...something about appropriate residential care and relationships with staff and other residents?
...something about assessments, short term memory, self-care and differential diagnosis?
...something about assessing risk to self?
...something about relationship with social services and other professional systems?
...something about the role of the Psychologist, MDT, etc?

Date: 16th May 2006
CASE DISCUSSION GROUP PROCESS ACCOUNT:

YEAR 1

SUMMARY

October 2005

Year 2
My Case Discussion Group (CDG) is made up of six, predominantly young, white, middle class, female trainees. Initially I was conscious of being much older than the others, and that most of them had considerable previous clinical experience, which I lacked. Our facilitator was male, older and worked systemically. He adopted a non-directive approach and made use of non-verbal gestures such as avoiding eye contact, which forced us to draw on the resources of the group and utilise the knowledge and ideas we had between us.

CDG meetings began with us each summarising our experience of placement and client work since we last met. We took turns to present a case each week, which was discussed by the others using systemic techniques such as reflecting teams and considering 'unheard voices'. Initially I marvelled at the knowledge of the others, who spoke authoritatively about theory and cases. In retrospect I wonder if we all wanted to appear capable, and so the focus was on success and competency rather than difficulties and uncertainties. Perhaps the power differential between the facilitator and trainees also affected what was discussed and how frank we were.

The group was supportive and nurturing, but the norm of validating may have led to members rarely challenging each other, and we may have learned more from each other if we had adopted a more critical stance. As the final meeting of the group approached I became conscious of my sadness at this impending ending, which seemed especially poignant as my placement and other course-related endings were happening at the same time. This made me aware of the potential impact endings may have on clients, when sessions might cease prematurely because of my progression from placement to placement, and of the importance of preparing clients for such endings.
CASE DISCUSSION GROUP PROCESS ACCOUNT:

YEAR 2

SUMMARY

July 2006

Year 2
We began the second year as an established cohesive group. Our new facilitator was female and worked behaviourally and cognitively; some group members knew her better than others because she was their clinical tutor. She let us structure the meetings and enforce our own boundaries.

Often the group was incomplete due to personal crises which occurred for some members. Between us we have experienced some big losses; my own was the sudden death of my father in March. Perhaps as a consequence the tone of the group has been much more emotional this year than last. I wonder how disruptive all this emotion has been to the work of the CDG, and whether it has meant too great a focus on personal rather than clinical issues.

I consider participating in my CDG to be the most valuable aspect of the university based part of the course and have appreciated the consistency if meeting regularly with a core group this year, particularly now that we change placements every six months, as it can be exhausting getting to know new colleagues so frequently.

A highlight of the year was our use of a video session to record ourselves discussing our reflections on being part of the CDG for the first 18 months. We then all watched that recording together several weeks later in order to reflect together again and consider our reactions to what was said.

I am aware we should prepare ourselves for the ending of the CDG next year and wonder whether our next facilitator will help guide us through this challenge, or will we have to manage it amongst ourselves? How will it be to grieve the ending while simultaneously celebrating the fact that what makes that ending a necessity is our success on the course?
PART 2:

CLINICAL DOSSIER

Details have been changed or omitted where necessary to preserve the anonymity and confidentiality of clients.
INTRODUCTION TO THE CLINICAL DOSSIER

The clinical dossier contains summaries of clinical work conducted and experience gained on four core competencies placements and one advanced competencies placement. There are also summaries of five case reports, full versions of the case reports, including references and appendices, are found in Volume II. Placement documentation including contracts, logbooks and evaluation forms can also be found in Volume II, which due to its confidential nature is held in the Department of Psychology at the University of Surrey.
SUMMARY OF CLINICAL PLACEMENTS

The names of supervisors and Trust details have been omitted to maintain confidentiality. Full details of placements can be found in Volume II of this portfolio.

JULY 2007

YEARS I TO I
Clinical Dossier: Summary of clinical placements

Adult Mental Health Core Competencies Placement

Dates: November 2004 to September 2005
Setting: Community Mental Health Team, with one day a week in Primary Care from May to September 2005 months.
Main models: CBT, integrative.
Presenting problems: Depression, anxiety, psychosis, PTSD, bipolar affective disorder, social phobia, obsessive compulsive disorder.
Client's age range: 18-76 years.
Experience: The work consisted primarily of one-to-one therapy undertaken independently, with clients from diverse cultural, religious and social backgrounds. Most clients were seen as outpatients, although one was visited at home. Standardised measures including the Beck Anxiety Inventory (BAI) and Beck Depression Inventory (BDI) were used to evaluate outcome. A neuropsychological assessment using the Wechsler Adult Intelligence Scale III (WAIS-III) was undertaken. A 'Psychosis Recovery' group was co-facilitated for 14 sessions with a clinical psychologist and nursing staff on an acute inpatient ward. An early intervention in psychosis conference was attended. A service related research project was conducted which investigated the provision of psychological therapies to people with a diagnosis of schizophrenia and their families.

People with Learning Disabilities Core Competencies Placement

Dates: October 2005 to March 2006
Setting: Community Team for People with Learning Disabilities
Main models: Systemic, integrative.
Presenting problems: Challenging behaviour, anger management, anxiety, depression, low self-esteem, suspected dementia, autism.
Client's age range: 23-76 years
Experience: The work was a mixture of one-to-one therapy, joint working, for example as a member of a reflecting team, and indirect working with the family members of two clients. Clients were seen as outpatients, at community venues and residential homes. Clients included those with significant and severe impairment, and came from diverse cultural, religious and social backgrounds. Work included an extended assessment with a female client with challenging behaviour, and the videoing and observation of a male client with challenging behaviour at meal times. A
Clinical Dossier: Summary of clinical placements

neuropsychological assessment (WAIS-III) was undertaken. A 'dementia workshop' was co-facilitated with another trainee clinical psychologist for the staff team of a residential home.

Child and Young People Core Competencies Placement

**Dates:** April 2005 to September 2005

**Setting:** Tier 2 and Tier 3 Child and Adolescent Mental Health Service

**Main models:** CBT, systemic, behavioural.

**Presenting problems:** Behaviour difficulties, sleep difficulties, depression, worry, anxiety attacks, obsessive compulsive disorder.

**Client's age range:** 2-14 years

**Experience:** The work involved indirect work with the parents of younger clients and one-to-one therapy with some older clients; several cases were worked jointly. The Strengths and Difficulties Questionnaire (SDQ) was used to evaluate the outcome of clinical work. Four school observations were conducted, and information was collected from teachers and special educational needs co-ordinators as part of assessments. Two neuropsychological assessments were conducted using the Wechsler Intelligence Scale for Children versions III and IV (WISC III and WISC IV), and an assessment for autistic spectrum disorder were conducted. A supportive psycho-educational group for the foster carers of adolescents was co-facilitated with a clinical psychologist from the looked after children team. Various continuing professional development events were attended including a Child and Adolescent Mental Health Service nursing conference and equality and diversity training.

Older People Core Competencies Placement

**Dates:** October 2006 to March 2007

**Setting:** Community Mental Health Team for Older People

**Main models:** CBT, narrative, adjustment.

**Presenting problems:** Depression, low mood, anxiety, memory difficulties, dementia, grief.

**Client's age range:** 57-85 years

**Experience:** The work was mainly one-to-one therapy, although some direct work with the family of one client was also undertaken. Clients were seen as inpatients, outpatients and at a day hospital; one was visited at home. The Hospital Anxiety and
Depression Scale (HADS) and Clinical Outcomes in Routine Evaluation (CORE) were used to evaluate the outcome of clinical work. A neuropsychological assessment was conducted using the Addenbrooks Cognitive Assessment (ACE-R) and the Behavioural Inattention Test (BIT). One client made an accusation of financial abuse against a family member, which necessitated liaison with social services. A supportive psycho-educational group 'Positive Ageing' was co-facilitated with two other trainee clinical psychologists. Consultancy work was carried out for an integrated falls service, which focused on various aspects of service improvements including the written communication provided to clients. A workshop for health professionals was facilitated with an occupational therapist; the focus was the 'stages of change model' and how this could be used to understand why some clients do not follow recommendations made.

Adolescent Service Advanced Competencies Placement

**Dates:** April 2007 to date

**Setting:** Adolescent Mental Health Team

**Main models:** Integrated systemic, CBT

**Presenting problems:** Eating disorder, depression, low self-esteem, obsessive compulsive disorder, school refusal.

**Client's age range:** 14-17 years

**Experience:** So far the work has been mainly one-to-one therapy, with some joint working as part of a reflecting team along with two family therapists, a nurse specialist and a specialist registrar. The work has included liaison with the GP of the client with an eating disorder and with staff at the special school attended by another client. The SDQ was used to evaluate the outcome of clinical work. Two neuropsychological assessments have been conducted using the WISC IV and the WAIS III. A child and adolescent mental health best practice seminar and a child and adolescent psychopathology conference have been attended.
CASE REPORT SUMMARIES

Details have been changed or omitted where necessary to preserve the anonymity and confidentiality of individuals.
ADULT MENTAL HEALTH CASE REPORT 1 SUMMARY

Assessment and treatment for a 38 year old woman presenting with depression and anxiety in the context of secondary sexual dysfunction.

REFERRAL

Maria McClennan is a 38 year-old, white, English speaking, middle class woman. She was referred to the Community Mental Health Team by the Dermatology Department she was attending for help with soreness that made sexual intercourse difficult. I observed the assessment conducted by a clinical psychologist; symptoms of moderate depression and anxiety were identified.

PRESENTING PROBLEM

Maria described low self-esteem, low mood, low libido and anxiety, which she attributed to a five-year history of gynaecological problems that make sexual intercourse agonising, and for which no physical cause had been identified.

ASSESSMENT

Clinical interviews and the referral letter were the sole sources of information used for the assessment.

Maria recalled feeling depressed since she was 11, although this was not diagnosed until she was 24; she had found antidepressants and counselling useful in the past. Maria had experienced chronic tonsillitis, an early menarche, and glandular fever.

Maria was born and brought up in a prosperous suburb; her parents live nearby and she has a younger brother and an older half brother. Maria recalled difficult early relationships with her father 'authoritarian ... depressed', and her mother 'very intense, stressful'. Maria described being treated as an extension of her mother and discouraged from becoming independent. She was not given pocket money; so was unable to buy clothing; she wore her mother’s caste offs, including underwear, until
she went to university. Maria's friendships were restricted when she was a child; other children were not allowed to visit her home, she became a loner at school.

Maria described past romantic relationships as being 'about obsessional lust, not healthy relationships'. The ending of her first relationship was 'very painful'. Maria met her fiancé on the Internet; they have a 'very good, warm, loving and supportive relationship' although their sexual relationship was difficult. They had set a wedding date six months from the assessment. Maria lives alone and is due to sell her flat shortly to buy a new house with her fiancé. Maria works for a gallery, and described her job as very stressful. She has several female friends whom she occasionally sees, but does not confide in.

Maria completed the Beck Anxiety Inventory (BAI) and the Beck Depression Inventory II (BDI II) to obtain baseline measures of her symptoms; her scores indicated 'mild-moderate' anxiety and depression.

FORMULATION

Maria reported a long history of depression which led to social withdrawal, which in turn led to symptoms of anxiety. I used a cognitive formulation to understand her difficulties.

Maria's early experiences included growing up in an atmosphere of parental invalidation with a father who was authoritarian and depressed and a mother who was intrusive and emotionally manipulative. She seems to have been discouraged from developing a sense of self-identity and self-esteem. This may have led to Maria forming core beliefs about her self such as 'I am unlovable' or 'I am not good enough'. Maria's early experiences of physical health problems may have led to the formation of core beliefs about her body as being vulnerable or unpredictable.

Maria had recently suffered gynaecological problems, was experiencing pressure at work and ambivalence about giving up her home. These could have served as critical incidents that activated her core beliefs, which in turn activated negative automatic thoughts leading to symptoms of anxiety and depression.
ACTION PLAN

As Maria planned to move home within a few months of her assessment she was offered eight to ten sessions of brief focused Cognitive Behaviour Therapy (CBT). Initial sessions would be used to:

- Establish the therapeutic alliance
- Provide psycho-education
- Socialise Maria to the CBT models of depression and anxiety.
- Facilitate the identification of Maria's goals of therapy.

I then intended to create a CBT treatment plan that would help Maria:

- Monitor her activities to clarify how she spends her time, and highlight any link between this and her mood.
- Learn to identify her negative automatic thoughts, seek evidence for and against them and develop alternative, more helpful thoughts.

INTERVENTION

Initial phase
I used the first sessions to establish the therapeutic relationship as previously I had only observed Maria's assessment sessions. I explained the CBT model and tried to help Maria differentiate her thoughts and feelings. It became apparent she had difficulty in identifying and owning her emotions; Maria described being punished as a child for any display of anger and said she had learnt to 'switch off' her feelings. Maria identified goals of exploring her thoughts and feelings in respect of her relationship with her parents, her self-identity and difficulties she has in attending work on time.

Middle phase
Maria's difficulty in identifying her emotions indicated she was not ready for the next stage of the action plan. This phase became an opportunity to help her identify her emotions and facilitate her goals of exploring her relationships and self-identity. Maria
was able to describe feeling 'angry and resentful' about her fiancé; this was the first time I had noticed her labelling her emotions.

I reviewed progress with Maria; her scores on the BAI and BDI II had reduced; although her anxiety symptoms were still in the 'mild-moderate' category her symptoms of depression had reduced to 'none or minimal'.

Maria revealed she had been raped five years previously; I consider this disclosure to be testament to the strength of therapeutic relationship which had become established. She also described other more recent distressing sexual incidents, since which she had never enjoyed sex. I began to see these as the critical incidents which triggered her other difficulties.

**Termination phase**

I started preparing Maria for the ending of therapy; she said she was pleased with her progress and planned to begin more psychological work once she had moved. But then she did not attend her two penultimate sessions. I was concerned Maria may have already disengaged from the therapy; perhaps she had found the talk of termination too painful and reacted by missing those sessions. I was left wondering if she would attend the final session we had arranged.
ADULT MENTAL HEALTH CASE REPORT 2 SUMMARY

Cognitive behavioural therapy with a 28 year old male presenting with social phobia

REFERRAL

Richard is a 28 year-old man who had been on the caseload of the Community Mental Health Team for two years following episodes of hypomania. Richard’s care coordinator referred him to the Behavioural Cognitive Psychotherapy Unit (BCPU) for assessment for social phobia; this referral was declined, as their acceptance criteria require the referee to have undergone a trial of CBT first. Richard was therefore referred to me for CBT.

Richard describes himself as white, British and atheist; his first language is English.

PRESENTING PROBLEM

Richard described himself as suffering from social phobia; he avoids social situations and eating in company.

ASSESSMENT

Information was gathered from Richard’s case notes, discussion with the Associate Specialist Registrar and clinical interviews.

Richard recalled his social phobia started shortly after he began secondary school, and contributed to him dropping out of his degree course.

Richard’s parents divorced when he was 10, having lived separate lives in the same house since he was three. Both parents worked full time and were rarely at home; Richard and his sister were brought up by au pairs.

Richard has no childhood memories of meal times as a family or with either parent, apart from ‘excruciating’ dinners with his father and sister when he was a teenager.
He recalls they made no effort to include him in the conversation, which often revolved around politics, and remembers feeling inadequate, wanting to participate, but not knowing what to say.

Since his parents divorced Richard has lived in various houses with each of them, their subsequent partners and the children of their subsequent partners; he currently lives with his mother, her current partner, and one of the partner's children. Richard finds this arrangement difficult and avoids social contact.

The Social Phobia Questionnaire (SPQ) (Leahy and Holland, 2000) and Social Phobia Rating Scale (SPRS) (Wells, 1997) were used to identify the social situations that make Richard anxious and the cognitive and behavioural factors which may be maintaining his social phobia.

No current risk factors were identified.

FORMULATION

The cognitive behavioural model has been identified as an effective way to conceptualise and treat social phobia, and CBT is the most widely used psychological treatment for this disorder (Rowa and Antony, 2005). Given this and the nature of the referral this model appeared appropriate to formulate Richard's case. Richard grew up in an atmosphere deprived of consistent social interaction, communication and feedback with few opportunities to develop and practice social communication skills. Throughout his childhood Richard's parents appear to have been unavailable to him, both physically and emotionally; he cannot recall any physical affection from either and was brought up by au pairs. His parents separated when he was young but continued living in the same house, each found a new partner and there may have been an undercurrent of guilt or anger in the communications Richard observed between his parents. The lack of adequate role models may have meant Richard had little opportunity to learn and rehearse social skills.
Richard cannot remember family meal times as a child apart from ‘excruciating’ dinners with his father and sister when he recalls they did not include him in conversation. Possibly Richard’s feelings of inadequacy at that time led him to develop core beliefs about himself as being unlovable, not interesting to others or not worthy of attention, and to assumptions like ‘if I speak I will be ignored or humiliated’ or ‘if I have nothing to say about politics people will think I’m ignorant or boring’. Social situations now, especially those that involve eating may remind him of how he felt then.

Richard’s hypomanic episodes appear to have corroborated his beliefs about his social inadequacy, triggering thoughts about himself being different to others and leading to avoidance and other safety behaviours that in turn help maintain his social anxiety.

**INTERVENTION**

Richard was offered ten sessions over three months.

I used the initial sessions to establish the therapeutic relationship, and explained to Richard that we were to engage in brief focused therapy to socialise him to the cognitive behavioural model, thus facilitating his referral to the BCPU. The initial phase also focused on psycho-education, and ascertaining Richard’s goals for therapy; he identified these as ‘to have a proper conversation with my father’ and ‘to have a social life I enjoy’. Richard brought a timeline of his life to one session, and described how constructing it had helped him link the development of his social phobia and hypomania to specific clusters of life events, which he had found helpful.

I used the middle phase to explore Richard’s relationships with family members and friends and his hypomania, as well as to work on his social phobia. We constructed an idiosyncratic conceptualisation of a social situation Richard found difficult, and he was able to identify negative automatic thoughts and safety behaviours. We also constructed a behavioural experiment for him to try as homework, and I taught him some distraction techniques to use which he said he found helpful in reducing his ruminations and anxiety. Richard also completed mood logs.
I used the final sessions to prepare Richard for the ending of therapy, reinforce his progress, review which techniques he had found helpful, and discuss his referral to the BCPU. The SPQ and SPRS measures were repeated for evaluation purposes; they indicated little change to the social situations that make Richard most anxious, and a reduction in the distress he experiences.

At the final session it was evident that Richard had made significant progress towards his goals; he had been able to speak with his father about his feelings and share my formulation with him. Also he attended a big family occasion, his grandfather's party, having been unable to attend a similar event, his sister's wedding, a few weeks before therapy commenced, and had also invited friends to his home. I regard this as substantial progress towards his goal of having a social life he enjoys and an indication that he has found the strategies useful.
PEOPLE WITH LEARNING DISABILITIES
CASE REPORT SUMMARY

Extended behavioural assessment with a woman in her thirties with moderate to severe learning disability and 'challenging behaviour'

REFERRAL

Ruby Kumar is an Asian woman in her mid thirties whose first language is English; she is thought to have autism and moderate to severe learning disability. She was referred to the Psychology and Challenging Needs Department (PCND) for investigation into possible depression. The team’s psychiatrist ruled out depression and forwarded the referral to me for behavioural work with Ruby’s obsessive behaviours, which were described as ‘challenging’.

PRE-ASSESSMENT

According to Ruby’s case notes she has a limited vocabulary but can make her needs known; she can speak English and a language of her native country. A speech and language report noted that Ruby has comparatively superior expressive language skills but her verbal comprehension is inconsistent and unreliable.

Further information was obtained from informal conversations with the referrer, the manger of Ruby’s residential home and her previous care manager.

Ruby was born overseas and has a younger brother. The family lived abroad until the 1980s when Ruby, her mother and brother moved to England because there were no suitable schools for Ruby in their original country. Ruby attended a community special school for children with severe learning difficulties until she was 19. She moved into the residential home for younger adults with severe learning disabilities sixteen years ago. Ruby’s mother, father and brother all currently live overseas.
Ruby attends a day centre for people with learning disabilities.

Functional Assessment Interviews (FAI, O’Neill et al., 1997) were conducted with the manager of Ruby’s home and her day centre link worker to obtain a description of Ruby’s ‘challenging’ behaviour. At home Ruby lines up items including the television and food jars to the edge of shelves and tables and shuts doors. She also eats food, often peanut butter or mayonnaise, when alone; amounts range from one teaspoonful to half a jar. At the day centre she moves items and has ‘tantrums’. I had difficulty understanding why some of these behaviours were regarded as ‘challenging’, although some do pose a potential risk to Ruby and others.

The initial assessment indicated attention from staff may be a maintaining consequence of the behaviours, which may be perceived by Ruby as rewarding. Lack of information made a comprehensive formulation impossible. An extended assessment was therefore necessary to test my initial hypotheses and structure an intervention.

EXTENDED ASSESSMENT

The extended assessment focused solely on Ruby’s behaviour at home as no further incidents were reported at the day centre.

I compiled a history of Ruby’s ‘challenging’ behaviours using information obtained from her case notes and conversations with her care manager and home manager, to clarify how long they have been a concern and whether they have altered, and to identify any historical events that might have contributed to them.

ABC recording charts were completed by staff at Ruby’s home to obtain a baseline measure of her behaviours and provide further information. Analysis of these charts revealed that almost every consequence results in Ruby receiving the direct attention of staff members, indicating this attention may reinforce her behaviour. Ruby’s behaviours decreased upon her return from a holiday with her family.
I conducted an ecological analysis which considered Ruby's physical, interpersonal and programmatic environments, to identify how well her environment meets her needs and help me understand what environmental changes may be required to provide the necessary support for her.

FORMULATION

My initial hypothesis was supported, and the information I obtained subsequently to the pre-assessment enhanced my understanding of Ruby's behaviour by highlighting a lack of opportunities for social interactions when at home, which might lead to her becoming bored. Ruby's behaviours may be maintained by the attention she receives from staff, providing interaction and stimulation. Ruby's behaviours may also result in some staff becoming irritated with her, therefore more likely to spend time in the office rather than interacting with her.

The possible impact on Ruby's vulnerability of her family living overseas and her lack of opportunity to interact with others of a similar cultural background to her also emerged as themes. Apparently Ruby's 'challenging' behaviours began within a year of her parents moving overseas, and appear to have ceased at the day centre following her most recent visit to her family. Having been brought up in an Asian family until she was 19, Ruby now has no opportunity to access her native culture apart from talking to her mother on the telephone or extended visits to her family.

Although Ruby eats regularly during the day it is possible she takes food because she is hungry; this behaviour being maintained by the subsequent reduction in her hunger after eating.
RECOMMENDATIONS

The recommended support plan suggested various interventions to reduce Ruby's 'challenging' behaviour, improve her long term quality of life and enable her carers to better understand her needs.

Ecological manipulations were recommended to make Ruby's environment more compatible with her needs. To improve Ruby's quality of life she should be given regular opportunities to talk about her family with staff made familiar with her background, found a culturally suitable befriender to enable her to talk about aspects of her cultural background, and given the opportunity to participate in active support, enabling her to become more engaged in the domestic aspect of living at the home. To reduce the frequency of Ruby eating food inappropriately she should be provided with a snack to eat at night. Positive programming should develop Ruby's functional skills and contribute to reducing the occurrence of her challenging behaviour by giving her the opportunity to participate in active support and develop new domestic skills. The frequency of Ruby's challenging behaviour may reduce if she is supported to develop strategies to initiate more casual communication with staff members rather than simply to make specific requests. An improvement in Ruby's quality of life might be achieved if she is referred for counselling to explore and express her emotions, in particular missing her family.

I suggested a staff meeting be called to share the formulation of Ruby's difficulties and enhance staff confidence in implementing the support plan.
CHILD CASE REPORT SUMMARY

Behavioural assessment and intervention with a three year old boy presenting with sleep difficulties

REFERRAL

Leo Brown was three years old when he was referred to the Child and Adolescent Mental Health Service by his health visitor because of sleep difficulties.

Leo's parents described him as English and his religion as Church of England.

PRESENTING PROBLEM

Leo's parents reported difficulties with settling him at bedtime and with him waking frequently during the night and then taking over an hour to settle. They estimated he slept for seven hours during the night, and 'not much' in the day. Mrs Brown described herself as exhausted by constant nights of broken sleep.

ASSESSMENT

The clinical interview and referral letter were the sole sources of information. The assessment was attended by Leo and both parents. Leo interrupted throughout and received attention from both parents, who apparently found it difficult to resist his demands.

Leo had always woken during the night; when younger he woke up to 15 times whereas now it was four or five times. Leo's parents tried various strategies including sticker charts and offering chocolate button rewards when he slept through the night but said this was unsuccessful. They were reluctant to try the controlled crying technique because of the risk of disturbing neighbours.
Mrs Brown had experienced 'postnatal' depression since Leo's brother Alex was born two years previously. She was taking antidepressants, and said she often cried.

The family live in an affluent suburb, both parents have demanding jobs. Mr Brown works full time. Mrs Brown works three extended days a week, during which Leo and Alex attend an exclusive day nursery.

Mrs Brown had a difficult pregnancy and consequently reduced the number of hours she worked. She had difficulty establishing breastfeeding; when Leo was five weeks old it was discovered he had tongue-tie, which was operated on. Leo's early difficulty in feeding meant that he woke frequently because he was hungry.

Leo's developmental milestones were achieved appropriately.

Mr Brown completed the Strengths and Difficulties Questionnaire P3/4 (SDQ; Goodman, 1997, 1999). This behavioural screening questionnaire revealed 'borderline' 'total difficulties' and 'emotional symptoms' scores, and an 'abnormal' 'conduct problems' score. All other scores were 'normal'.

No risks were identified.

FORMULATION

Leo was born with tongue-tie; by the time this was identified and rectified a pattern of him waking frequently and wanting to be fed had become established. Leo's parents were concerned that his night time crying would disturb neighbours and so allowed an extended bedtime routine to develop. They responded to his crying by going to his room to settle him, therefore he has not learnt to settle himself and cannot fall back to sleep when he wakes during the night. Leo has learnt that if he cries a parent will respond; this acts as a positive reinforcer because Leo receives attention and cuddles, and may also
act as a negative reinforcer by removing an unpleasant experience of loneliness or boredom.

Mrs Brown is exhausted by being woken during the night, this and her 'postnatal' depression may contribute to her difficulty in tolerating Leo's crying at night; her low mood may then be exacerbated by lack of sleep.

**ACTION PLAN**

As the formulation highlighted the role of learning in the development of Leo's sleep difficulties a behavioural intervention was appropriate. Two sleep problems were identified; it was agreed to prioritise settling Leo at bedtime. The initial focus would be on reducing his bedtime routine in order to teach him to settle more quickly. If necessary the focus would then move to helping Leo settle himself when he wakes during the night. Sleep diaries would be used throughout the intervention to monitor changes in Leo's sleep pattern; Mrs Brown was given one to complete in order to establish a baseline measure.

**INTERVENTION**

The intervention consisted of five sessions; Mrs Brown attended one alone, one with Leo, and three with Leo and Alex. When both boys attended Alex was mostly able to occupy himself, but Leo constantly sought his mother's attention. She would hug and kiss him and direct his attention to a toy, which diverted him briefly; I often found it hard to engage her as she was distracted by Leo's behaviour.

The initial sleep diary revealed it took 15-90 minutes for Leo to fall asleep after being put to bed and he woke at least once during every night but one.

I encouraged Mrs Brown to set clear bedtime boundaries for Leo; as offering him stickers had been an unsuccessful incentive I advised her to discontinue. Instead I devised a
chart which incorporated positive reinforcement for appropriate behaviour and negative punishment for inappropriate behaviour. Points were awarded and when an agreed number were obtained a tangible reward given.

The penultimate sleep diary revealed Leo had slept through several nights and averaged 10 hours sleep each night, which Mrs Brown regarded as insufficient. She was now concerned that Leo was having tantrums because he was tired. I suggested that 10 hours could be enough as Leo wakes naturally in the morning; three-year-olds can need to spend anything between eight and 14 hours out of 24 sleeping (Health Promotion England 'Birth to Five'; 1999, pp.55). To ascertain whether there was a link between the amount of time Leo slept and his tantrums further columns were added to the sleep diary to record the time and severity of tantrums.

When Mrs Brown and Leo attended the final session they both looked happy and less tired, and Leo immediately played by himself. Mrs Brown showed me the final sleep diary, which she described as 'a real success story'. Leo had slept through eleven out of fourteen nights; he had achieved his first reward and was now making progress towards the next. Although several tantrums were recorded most were not severe and Mrs Brown was not concerned by them.

**OUTCOME**

Mrs Brown completed a final SDQ; Leo's scores were much improved. His 'total difficulties' and 'emotional symptoms' scores were 'normal'; his 'conduct problems' score remained 'abnormal' but had reduced and, importantly, Mrs Brown now regarded his conduct as manageable.
OLDER PEOPLE CASE REPORT SUMMARY

Neuropsychological assessment of an 85 year old man presenting with vivid dreams.

REFERRAL

Mr Peter Thomas is 85 years old and was referred by his GP because he experienced distressing vivid dreams. The referral was passed to me by the community psychiatric nurse (CPN), who first conducted a Mini Mental State Examination (MMSE; Folstein et al., 1975) on which Mr Thomas scored 29/30. The CPN postulated these dreams might indicate delayed Post Traumatic Stress Disorder (PTSD).

Mr Thomas described himself as white, British and Catholic; his first language is English, he is right handed.

PRESENTING PROBLEM

Mr Thomas' vivid dreams began when he was in hospital following a hip fracture a year previously. He became concerned that they were caused by changes in his brain because of his strokes, fall or ageing and was worried he was developing Alzheimer's disease (AD) despite being aware vivid dreams are not symptoms of this condition.

INITIAL ASSESSMENT

Information was gathered from clinical interviews and discussions with the CPN, GP and Consultant Psychiatrist.

Mr Thomas described his childhood as 'happy', and his parents as 'kindly' and 'not demonstrative'; he has a younger sister. Mr Thomas married at the end of the Second
World War, the couple moved to the house where he still lives, and had three children. His wife died at home twelve years previously.

Mr Thomas went to boarding school, then began a career in journalism and at the outbreak of World War Two joined the Royal Air Force. He was decorated for a distinguished war record, then returned to journalism and later held a senior position in an aviation company.

Mr Thomas has experienced three strokes, the second led to his left side becoming weak, and the most recent was multi-infarct. He is wheelchair dependent following a hip fracture sustained from a fall eighteen months previously. He has a pacemaker and indwelling catheter, and takes medication for various medical conditions, including some to reduce the risk of further strokes. Mr Thomas did not report a history of head injury.

Mr Thomas lives at home, live-in carers move him between his wheelchair and bed or armchair with a hoist. He sees or speaks to his children and sister regularly and has frequent visitors.

**FORMULATION**

Mr Thomas' dreams did not indicate the persistent re-experiencing of a traumatic event required by the DSM-IV (American Psychiatric Association; 1994) diagnostic criteria for PTSD, nor did he report other symptoms indicative of PTSD.

Mr Thomas expressed anxiety that he may be developing AD but did not describe symptoms typical of this condition. This combined with his score of 29/30 on the MMSE indicated AD was unlikely.

Following an active and successful earlier life, Mr Thomas experienced the loss of his wife, mobility, physical health and independence. The suddenness of some of these events may have left him aware of his future being uncertain. Anxiety created by this
awareness perhaps lead to him becoming vigilant for signs of another imminent loss, particularly related to his health. The dreams and request for help were seen as part of Mr Thomas' adjustment to loss and disability, reflecting a concern about loss of intellectual functioning.

**ACTION PLAN**

1. Provide psycho-education regarding the nature of sleep and dreams to help normalise Mr Thomas' experience.

2. Conduct a brief neuropsychological assessment to directly address Mr Thomas' concerns about a possible decline in his cognitive functioning. As Mr Thomas is in poor physical health and tires easily the investigation would be as brief and undemanding as possible.

3. Provide feedback regarding assessment findings, with recommendations if appropriate.

**FURTHER INVESTIGATIONS**

Mr Thomas' pre-morbid intellectual functioning was assessed with the Wechsler Test of Adult Reading (WTAR; The Psychological Corporation, 2001); his score indicated a pre-morbid IQ in the high average range.

The Addenbrooke's Cognitive Examination (ACE-R) (Mioshi *et al.*, 2006) was used to assess Mr Thomas' current cognitive functioning. Mr Thomas' response on the reading subtest and performance on the visuo-spatial subtests indicated he might experience Unilateral Visual Neglect (UVN) which is common following a stroke (Verfaellie, 1998). According to Wilson *et al.* (1987; pp4) UVN is characterised by 'failure to respond to objects or situations in the space contra-lateral to the cerebral lesion'. As Mr Thomas
had neglected the left side of drawings in this test it seemed likely he had sustained damage from strokes in his right hemisphere.

To clarify whether Mr Thomas experienced UVN I administered the Behavioural Inattention Test (BIT) (Wilson et al. 1987), which consists of conventional and behavioural subtests. The conventional subtests are used to define the presence or absence of UVN; Mr Thomas' score indicated this was present. The behavioural subtests were not used; it was unlikely they would provide useful additional knowledge about Mr Thomas' condition, and I was mindful that he tired easily.

A Computerised Tomography (CT) scan requested by the consultant psychiatrist identified damage caused by a stroke in Mr Thomas' right parietal lobe. Verfaellie notes parietal lobes are responsible for orientation of attention and spatial representation; damage to this area was consistent with Mr Thomas' presentation.

CONCLUSIONS

The assessment results appear to give a reliable estimate of Mr Thomas' functioning, although the interpretation of his scores on the MMSE and the ACE-R was made with caution. Mr Thomas' performance on the BIT indicates he experiences some visual neglect which would have affected his performance in some areas of testing, therefore his score on the ACE-R cannot necessarily be considered valid in terms of indicating dementia.

These results place Mr Thomas in the impaired range on the MMSE and ACE-R. The most likely cause is normal ageing and strokes that may have caused vascular dementia, which is found in around a third of people in their eighties following stroke (Tatemichi et al. 1990). The pattern of Mr Thomas' responses is not indicative of AD.
FEEDBACK

I visited Mr Thomas to feedback the assessment results and suggested several strategies to minimise the impact of the difficulties indicated; his carer agreed to help him with them.
PART 3:

RESEARCH DOSSIER
INTRODUCTION TO THE RESEARCH DOSSIER

The research dossier contains the Service Related Research Project, which was submitted in Year 1, the abstract of a Qualitative Research Project which was submitted jointly with four other trainee clinical psychologists in Year 2, the Major Research Project was submitted in Year 3 and the Research Logbook. Some details have been omitted to maintain confidentiality and anonymity.
SERVICE RELATED RESEARCH PROJECT

AN INVESTIGATION INTO THE PROVISION OF PSYCHOLOGICAL THERAPIES TO PEOPLE WITH A DIAGNOSIS OF SCHIZOPHRENIA AND THEIR FAMILIES BY STAFF OF A COMMUNITY MENTAL HEALTH TEAM AND AN ACUTE ADMISSIONS WARD

Year 1
July 2005
ABSTRACT

Title: An investigation into the provision of psychological therapies to people with a diagnosis of schizophrenia and their families by staff of a community mental health team and an acute admissions ward.

Objective: To explore whether psychological therapies are currently being offered to people with a diagnosis of schizophrenia and their families by the staff of the community mental health team and the acute admissions ward in accordance with NICE (2002) guidelines. Also, to identify whether more psychological therapies could be offered with current levels of training and whether there is a demand for training to enable staff to provide them.

Design: Semi-structured survey using a combination of closed and open questions.

Setting: Community mental health team and acute admissions ward.

Participants: Clinical staff in the above settings.

Main Outcome Measures: Broad question areas: current profession, level of training, qualifications obtained, work setting, any training received in using psychological therapies, any experience in using psychological therapies, whether currently providing psychological therapies, whether interested in training in order to provide psychological therapies.

Conclusions: This audit found that psychological therapies are being offered to people with a diagnosis of schizophrenia and their families by staff in both settings; it is unlikely that provision is adequate to meet the NICE guidelines. Some staff have received training in CBT and Family Interventions but do not currently provide it, citing lack of supervision amongst other reasons. There is strong demand from staff for training in CBT and Family Interventions as well as other therapies.
ACKNOWLEDGEMENTS

I wish to acknowledge the help and support I have received with this project from the staff at the CMHT, the ward manager, and especially my service related research project supervisor.

INTRODUCTION

NICE Guidelines
The National Institute for Clinical Excellence (NICE) guidelines (Compilation: Summary of Guidance issued to the NHS in England and Wales, Issue 7, October 2003. Pages 233 and 237 to 238) provide an evidence-based recommendation of best practice in the treatment of schizophrenia. The guidelines state that psychological therapies should be offered to users of mental health services who have a diagnosis of schizophrenia and also to their families. Specifically, cognitive behavioural therapy (CBT) is recommended as a treatment option for people with schizophrenia and family interventions (FI) for 'the families of people with schizophrenia who are living with or who are in close contact with the service user' (pages 237 and 238 respectively). The guidelines do not state by whom these therapies should be provided.

CBT
The NICE (2002) guidelines state that '100% of individuals with schizophrenia who are experiencing persisting psychotic symptoms should be offered CBT' (page 55), which should include more that ten sessions over a period of at least six months.

Durham, Guthrie, Morton, Reid, Treliving, Fowler and Macdonald (2003) note that CBT 'aims to help sufferers understand and manage their experience of psychosis in ways that reduce distress and interference with functioning' (page 303); they found CBT produced 'significantly greater improvement in overall symptom severity' (page 303) when compared to supportive psychotherapy or treatment as usual.
Family Interventions
The NICE (2002) guidelines also state that Family Interventions (FI) should ‘be offered to 100% of families of individuals who have experienced a recent relapse, are considered to be at risk of relapsing, or who have persisting symptoms’ (page 54). It is suggested that FI should consist of at least ten sessions over a period of more than six months.

In their meta analysis of FI studies, Mari and Streiner, 1994; 1995 (cited in Fadden, 1997) found the benefits of FI included a reduction in relapse rates, decreased hospitalisations and improved compliance with medications, all of which could be expected to result in decreased costs to mental health services.

Provision of Therapies by CMHT and ward staff
In line with the NICE (2002) guidelines, this audit will investigate whether psychological therapies are currently being offered to users of mental health services who have a diagnosis of schizophrenia and to their families by the clinical staff of the community mental health team (CMHT) and the acute admissions ward ('the ward'). It will also investigate whether more psychological therapies could be offered with current levels of training and whether there is a demand for training to enable staff to provide them.

The audit will expand on two previous audits conducted within the mental health trust, one by a consultant clinical psychologist and a consultant nurse and one by a consultant nurse, during the preceding year. These were:

1. An audit of skills relevant to implementation of the NICE schizophrenia guidelines – psychological intervention.
2. A psychosocial intervention audit.

The former audit sought to identify the organisational training needs that should be addressed in order to implement the NICE schizophrenia guidelines equitably across the boroughs covered by the mental health trust. Team managers asked all team members working in the adult mental health directorate to complete a ‘brief’ questionnaire and
responses were received from 39% of them. Recommendations from this audit included the provision of training in CBT, family work and supervision and the increased availability of supervision, although the limitations of extrapolating from such a low response rate were acknowledged.

The latter audit investigated those known to have attended previous psychosocial interventions training in order to assess the level of training need, practitioners current practice and their ability to implement interventions outlined in the NICE guidelines. Data was gathered using postal or electronic questionnaires which extended to six A4 pages and had a response rate of 33%. This audit found that the majority of respondents do use the interventions 'despite experiencing difficulties in obtaining supervision during and after training'.

It was hoped that this smaller scale audit would investigate the provision of therapies and the demand for training and supervision in more depth by asking specific questions designed to identify reasons why training was not being used and whether any difficulties were experienced in accessing supervision. It was also hoped that a substantially improved response rate would be achieved compared to those of the above-mentioned audits by using a very short questionnaire and by the researcher directly approaching potential respondents and asking them to participate. By concentrating on one CMHT and one ward it was hoped that staff who knew the researcher personally would be more likely to complete the questionnaire, thus enhancing the response rate.

The underlying rational for conducting this audit was that the results could be used to improve the service by identifying what provision of CBT and FI might be possible with existing training levels, to identify what training had been received and whether it was being utilised, and to identify what training and supervision needs exist.
RESEARCH QUESTIONS

Are staff currently offering psychological therapies to clients with a diagnosis of schizophrenia, and if not which therapies could they be offering with their existing skills? Which ones would they like to offer if given appropriate training?

METHOD

Design
A semi-structured survey using a questionnaire containing a combination of closed and open questions.

Production of the questionnaire
Once the research question had been agreed, a research proposal form was completed and submitted for approval (see Appendix I). When approval had been obtained, suitable question areas were identified and a questionnaire constructed to obtain further information. The questionnaire was designed to fit onto two sides of A4 paper and prepared on one double-sided sheet in order to save paper in accordance with the relevant mental health trust policy.

Pilot
The completed questionnaire was piloted amongst three staff at another CMHT within the same mental health trust to ensure that it was easy to understand and complete; comments were invited from the pilot group. One pilot participant failed to complete the reverse side of the questionnaire despite the instruction to 'please turn over'. It was therefore decided to use two one-sided sheets for the main data collection to avoid respondents in the main study making a similar mistake. No other errors were made in the completion of the pilot questionnaires and no suggestions were received so this was
the only change made to the original document. A copy of the final questionnaire can be found in Appendix II.

**Participant selection**
All clinical staff working at the CMHT and on the acute admissions ward were asked to complete the questionnaire as their roles would potentially enable them to provide CBT or FI.

**Data collection**
The researcher attended a team meeting at the CMHT to describe the study to team members and request that they complete the questionnaire. Of the five clinical staff members present, four completed the questionnaire and one declined. With consent of the CMHT team manager, questionnaires and a covering note were placed in the pigeonholes of the four staff members who had been unable to attend the team meeting and these questionnaires were eventually completed and returned to the researcher as requested. In all, eight of the nine questionnaires were completed and returned, indicating a response rate from the CMHT staff of 89%.

At the suggestion of the ward manager, the researcher attended the ward to approach staff individually in order to explain the purpose of the study and ask them to complete the questionnaire. Five staff members were approached directly; three completed the questionnaire, one declined and one said they would complete it later. Following further discussion with the ward manager, questionnaires with covering notes were placed in the pigeonholes of twenty of the remaining staff members; four further completed questionnaires were eventually received. In all, seven of the twenty-five questionnaires were completed and returned, indicating a response rate from the ward staff of 28%.

Overall, fifteen of the thirty-four questionnaires were completed and returned, indicating a response rate across both settings of 44%.
ANALYSIS AND RESULTS

Respondents
Fifteen completed questionnaires were received; of these two were disregarded, one because it had been completed by a staff member who had a non-clinical role and one because it contained insufficient information. As can be seen in Figure 1, of the thirteen remaining participants five were female and eight were male. Two participants did not reveal their ages; those who did reported ages ranging from twenty-five to fifty-four with a mean age of forty-one. Nothing is known about the demographics, skills or training of the individuals who were non-responders.

![Figure 1: Gender of Participants](image)

Participants were asked to identify their current main work setting; as illustrated by Figure 2, eight participants specified the CMHT and five the ward.
Table 1 illustrates the professions of the respondents to the questionnaire; nursing was the most commonly cited profession, with three community psychiatric nurses (based at the CMHT) and three registered mental health nurses (based on the ward).

Table I: Profession of respondents

<table>
<thead>
<tr>
<th>Profession</th>
<th>n.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Psychologist</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Community Psychiatric Nurse</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Deputy Ward Manager</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Registered Mental Health Nurse</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>Senior House Officer</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>14</td>
</tr>
<tr>
<td>Team Manager</td>
<td>1</td>
<td>8</td>
</tr>
</tbody>
</table>

The length of time staff had been qualified varied between six months and twenty-four years, with a mean of almost ten years.
Responses to CBT questions

Six of the thirteen respondents said they had received training that would enable them to provide CBT to clients/patients with a diagnosis of schizophrenia. Of these, three said that they do currently provide this. Table 2 illustrates how many staff reported receiving training to provide CBT and how many utilise this training in each of the locations:

<table>
<thead>
<tr>
<th>Location</th>
<th>Trained, using CBT</th>
<th>Trained, not using CBT</th>
<th>No CBT training</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHT</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Ward</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

The three respondents who were using CBT stated that they had access to appropriate supervision in their clinical setting; the three who had received training but were not using CBT said they did not have access to such supervision.

The respondents who had received training in CBT but were not currently providing it also cited various other reasons for this:

- Rusty skills
- Insufficient training
- Insufficient time
- Pressure of work load
- Working reactively for too long
- High turnover of patients
- Lack of reflective practice
- Inadequate staffing level
- High activity level
There was considerable interest expressed in receiving CBT training with nine of the respondents stating an interest in introductory training and one in refresher training, as illustrated by Table 3.

**Table 3: Interest in CBT training**

<table>
<thead>
<tr>
<th>Location</th>
<th>Introductory</th>
<th>Refresher</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHT</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ward</td>
<td>4</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Responses to Family Interventions questions**

Five of the thirteen respondents said they had received training that would enable them to provide FI to the families of clients/patients with a diagnosis of schizophrenia. Of these, two said that they do currently provide this. Table 4 illustrates how many staff reported having received training to provide FI and how many actually utilise this training in each of the locations:

**Table 4:**

<table>
<thead>
<tr>
<th>Location</th>
<th>Trained, Using FI</th>
<th>Trained, not Using FI</th>
<th>No FI training</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHT</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Ward</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

In addition, one member of the CMHT staff reported providing FI despite not having received appropriate training.

Of the three respondents who were using FI, two stated that they had access to appropriate supervision in their clinical setting and one did not; the three who had received training but were not using FI said they did not have access to such supervision.
The respondents who had received training in FI but were not currently providing it cited two other reasons for this:

- Lack of access to families
- No time available

There was considerable interest in receiving FI training with eight of the respondents stating an interest in introductory training and one in refresher training, as illustrated by Table 5.

Table 5: Interest in FI training

<table>
<thead>
<tr>
<th>Location</th>
<th>Introductory</th>
<th>Refresher</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMHT</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ward</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Responses to Other Therapies questions.
Respondents were asked what other therapies they provide to clients/patients with a diagnosis of schizophrenia and/or their families; the most commonly noted were supportive counselling (cited by five respondents) and relapse prevention (cited by two respondents).

The final question asked respondents what other training they would like to be available to enhance their work with clients/patients with a diagnosis of schizophrenia and/or their families. Responses to this question included:

- Anxiety management
- Relaxation
- Counselling skills
- Brief based solution therapy
DISCUSSION

This audit sought to explore whether CBT is currently being offered to people with a diagnosis of schizophrenia and whether FI is currently being offered to their families by the staff of the CMHT and the acute admissions ward. Also, to identify whether more psychological therapies could be offered with current levels of training and whether there is a demand for training to enable staff to provide them.

Three of the CMHT staff currently offer CBT and one each of the CMHT and the ward staff currently offer FI. The CMHT has a caseload of 302 and the ward has 22 beds; clients and patients have various diagnoses including depression and anxiety as well as schizophrenia. It seems unlikely that the level of psychological therapy provision identified in this audit is sufficient to meet the NICE (2002) guidelines of being offered to 100% of individuals with schizophrenia and their families. Although the audit identified staff members who were trained in and using CBT and FI, it is not possible to know from this audit if those who said they did provide therapies did so to an adequate standard. Also, it is not possible to identify from this audit how many clients and patients have been offered CBT or how many of their families have been offered FI; any future audit should seek to clarify this in order to ascertain how the service offered compares to the NICE (2002) guidelines. It should however be remembered that the NICE guidelines are just that, guidelines. They are a recommendation of what is currently viewed as best practice to which services strive, but resourcing difficulties may mean that they are not achievable.

The Mental Health Trust in which the audit was conducted is currently in financial difficulties, which may well result in a decreased training budget; it is therefore essential that current expertise is identified and utilised, and that staff who have received training are encouraged to make use of it.

Could more psychological therapies be offered with current levels of training? The audit identified three ward staff who were trained in CBT but not providing it; all three stated
that they do not have access to appropriate supervision in their clinical setting. Also, two of the ward staff and one of the CMHT staff are trained in FI but not providing it, and again all three indicated that they do not have access to appropriate supervision in their clinical setting. Lack of appropriate supervision would therefore appear to be a significant factor in why CBT and FI are not provided by staff qualified to do so. However, this was only one of many reasons cited by staff which contributed to their being unable to provide CBT or FI despite having been trained to do so; other factors included rusty skills, insufficient training, insufficient time, working reactively for too long and a high turnover of patients.

A lack of suitable families was cited as a reason why FI was not offered, although perhaps suitable families do exist who are not being identified. Fadden's (1997) research into the implementation of FI found that therapists cited 'the lack of suitable or appropriate families'; she speculated that this might 'reflect an attitudinal problem ... of what constitutes a 'suitable' family ... or difficulties in engagement of families'. Future research might investigate what can be done to ensure families are being identified to ensure they are offered the service.

Is there a demand for training to enable staff to provide psychological therapies? Ten (77%) respondents registered an interest in CBT training and the same number in FI training, so there is a demand. It is important to recognise that clinical judgement is necessary to decide which interventions should be used, and that CBT or FI may not always be appropriate. Staff also expressed an interest in receiving training in anxiety management, relaxation, counselling skills and brief solution based therapy. However, as already seen, access to training does not guarantee that it will be put into practice due to the various other factors already mentioned.

The overall response rate for this audit was 44%, which compared favourably to the response rates of 33% and 39% achieved respectively by the 'psychosocial intervention audit' and 'audit of skills relevant to implementation of the NICE schizophrenia guidelines – psychological interventions' conducted within the trust in the previous year. However
the response rate did not achieve a level that could be described as 'substantially improved', as had been hoped.

There are several reasons why staff may have been reluctant to complete the questionnaire, although it is only possible to hypothesize as to what these might be. Maybe staff were too busy to complete the questionnaire. Perhaps some felt threatened by the evaluation; they may have had concerns about how the findings might be used, for example if the trust had paid for training which was not used by the staff member, would this result in that individual not having access to training in the future? Also, the ward manager speculated that staff might have been 'questionnaired out' as they had been asked to complete several questionnaires recently.

Although only 28% of the questionnaires distributed to ward staff were returned, the ward manager felt that the replies would be generalisable to the rest of the staff. He also suggested that by attending a handover meeting on the ward, distributing the questionnaires and waiting for them to be completed, the researcher might have achieved a greater response rate.

The results of this audit will be presented to the CMHT staff at a team meeting, and to the ward manager at a one-to-one meeting, in August 2005.
REFERENCES

Audit of skills relevant to implementation of the NICE schizophrenia guidelines – psychological interventions (2004) (Name of mental health trust omitted in order to preserve anonymity)


Psychosocial Intervention Audit (2004) (Name of mental health trust omitted in order to preserve anonymity)

APPENDIX I

RESEARCH PROPOSAL FORM
TRAINEE'S NAME:

Project Title:
An investigation into the provision of psychological therapies to people with a diagnosis of schizophrenia and their families by staff of a Community Mental Health Team and an Acute Admissions Ward.

Theoretical Rationale:
National Institute for Clinical Excellence guidelines (Compilation: Summary of Guidance issued to the NHS in England and Wales, Issue 7, October 2003. Pages 233 and 237 to 238) state that psychological therapies should be offered to users of mental health services who have a diagnosis of schizophrenia and also to their families, but they do not state by whom. This study will investigate whether psychological therapies are currently being offered to users of mental health services who have a diagnosis of schizophrenia and also to their families by members of the staff of the Community Mental Health Team and the Acute Admissions Ward, whether more psychological therapies could be offered with current levels of training and whether there is a demand for training to enable staff to provide them.

Objective(s):
To explore whether psychological therapies are currently being offered to people with a diagnosis of schizophrenia and to their families by the staff of the Community Mental Health Team and the Acute Admissions Ward. Also, to identify whether more psychological therapies could be offered with current levels of training and whether there is a demand for training to enable staff to provide them.

Design:
A semi-structured survey using a combination of closed and open questions.

Setting:
Community Mental Health Team and Acute Admissions Ward
Participants:
Multi Disciplinary Team staff and ward staff

Procedures:
- Presentation at team meeting(s) explaining rationale for study and inviting questions and suggestions from the team in order to foster collaborative working prior to the commencement of data collection.
- In consultation with placement supervisor a questionnaire and information sheet will be devised. The questionnaire will incorporate some closed and some open questions to allow for a richer type of data to be gathered.
- The questionnaire and information sheet will be distributed to staff in the Community Mental Health Team and on the Acute Admissions Ward, who will be asked to complete the questionnaire within a specified time period and return it to the researcher.
- If some questionnaires have not been returned within the time specified the researcher is to follow up with the team and/or ward concerned.
- Information gleaned from the completed questionnaires to be analysed descriptively.

Main hypotheses (quantitative projects)/research questions (qualitative projects):
Research question: are staff currently offering psychological therapies to clients with a diagnosis of schizophrenia, and if not which therapies could they be offering with their existing skills and which ones would they like to offer if given appropriate training?

Main outcome measures (quantitative projects)/broad question areas in interview (qualitative projects):
Broad question areas: current profession, level of training in current profession, qualifications obtained, current work setting, any training received in using psychological therapies, any experience in using psychological therapies, currently providing psychological therapies as part of role, interest in training in order to provide psychological therapies.
Statistical analyses (quantitative projects)/type of qualitative analyses:
Descriptive statistics

Ethical considerations:
Staff may feel anxious or inadequate if asked to complete a questionnaire which appears to suggest their current level of training is insufficient, or they may be concerned that a requirement to provide psychological therapies will further increase their work load. The information sheet provided along with the questionnaire will stress that this is an information gathering exercise.

Responses will not be anonymous, as by stating their professions and levels of training respondents will almost certainly identify themselves, however confidentiality will be maintained as far as possible and results will be presented in such a way that individuals are not singled out.

University Supervisor: Dr

Field Supervisor: Dr

Name of Ethics Committee(s) to which project will be submitted: N/A

Date of next Ethics Committee(s) meeting(s): N/A

Date of next Research and Development Committee meeting: N/A

Signature of trainee: 
Date: 

Signature of supervisor: 
Date: 

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APPENDIX II

CBT/FI QUESTIONNAIRE
CBT/FI QUESTIONNAIRE

This short questionnaire is to investigate the availability of psychological therapies to people with a diagnosis of schizophrenia and their families in accordance with the NICE Schizophrenia Guidelines and also the demand for training in the provision of these therapies.

Confidentiality will be maintained and the results of this questionnaire will be presented in such a way that individual respondents will not be identified.

Please tick the response that most applies to you

Part A – Your Details

Q1) Gender: Female ☐ Male ☐ Q2) Age: ☐

Q3) What are your professional qualifications? ____________________

and your current profession? ____________________

Q4) How long have you been qualified in current profession? ☐ Years

Q5) Current main work setting: CMHT ☐ Ward ☐

Part B – CBT

Q6) Have you received any training which would enable you to provide CBT to clients/patients with a diagnosis of schizophrenia?

Yes ☐  Go to question 7  No ☐  Go to question 11

Q7) What level training have you had? i.e. module, diploma ________________

Go to question 8

Q8) Do you currently provide CBT to clients/patients with a diagnosis of schizophrenia?

Yes ☐  Go to question 9  No ☐  Go to question 10
Research Dossier: Service related research project

Q9) Do you have access to appropriate supervision in your clinical setting for the CBT you provide?
   Yes ☐ Go to question 11   No ☐ Go to question 11

Q10) If you have received training in CBT but do not currently provide it to clients/patients is this because of (please tick all that apply):

☐ Lack of appropriate clients/patients
☐ Rusty skills
☐ Lack of appropriate supervision in your clinical setting
☐ Insufficient training
☐ Other reason (please give details)

Q11) Would you be interested in receiving training in CBT?
   Yes, introductory training ☐ Yes, refresher training ☐ No ☐

Part C – Family Interventions

Q12) Have you received any training which would enable you to provide Family Interventions to the families of clients/patients with a diagnosis of schizophrenia?
   Yes ☐ Go to question 13   No ☐ Go to question 17

Q13) What level training have you had? i.e. module, diploma ____________
   Go to question 14

Q14) Do you currently provide Family Interventions to the families of clients/patients with a diagnosis of schizophrenia?
   Yes ☐ Go to question 15   No ☐ Go to question 16

Q15) Do you have access to appropriate supervision in your clinical setting for the Family Interventions you provide?
   Yes ☐ Go to question 17   No ☐ Go to question 17
Q16) If you have received training in Family Interventions but do not currently provide it to the families of clients/patients with a diagnosis of schizophrenia is this because of (please tick all that apply):

☐ Lack of appropriate families
☐ Rusty skills
☐ Lack of appropriate supervision in your clinical setting
☐ Insufficient training
☐ Other reason (please give details)

Q17) Would you be interested in receiving training in Family Interventions?
Yes, introductory training ☐ Yes, refresher training ☐ No ☐

Part D – Other therapies

Q18) What other therapies do you provide to clients/patients with a diagnosis of schizophrenia and/or their families?

Q19) What other training would you like to be available to you to enhance your work with clients/patients with a diagnosis of schizophrenia and/or their families?

Thank you for completing the questionnaire.
The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust's ethical committee.

Name of Supervisor: ..................................................  
Signature of Supervisor: .............................................

Name of Trainee: CLAIRE FORD

Title of SRRP: An investigation into the provision of psychological therapies to people with a diagnosis of schizophrenia and their families by staff of a Community Mental Health Team and an Acute Admissions ward

Date: 20/12/04

Information removed to retain anonymity
5th September 2005

To whom it may concern

AN INVESTIGATION INTO THE PROVISION OF PSYCHOLOGICAL THERAPIES TO PEOPLE WITH A DIAGNOSIS OF SCHIZOPHRENIA AND THEIR FAMILIES BY STAFF OF A COMMUNITY MENTAL HEALTH TEAM AND AN ACUTE ADMISSIONS WARD

This letter is to confirm that Claire Pond presented the results of the above Service Related Research Project on Monday 22nd August 2005.

The presentation was attended by 8 members of the multi-disciplinary team including the team manager and the consultant psychiatrist, both of who requested and were given copies of the report.

The team was interested in the results obtained and the presentation led to a discussion regarding provision of more training and support for the staff with regards to the provision of psychological therapies.

Yours sincerely

Chartered Clinical Psychologist
QUALITATIVE RESEARCH PROJECT

A DISCOURSE ANALYSIS OF UK NATIONAL DAILY NEWSPAPERS' REPRESENTATIONS OF 'PAEDOPHILES'

Year 2
May 2006
ABSTRACT

Background: Print media is regarded as significantly influential on the public's moral position (Farrow & Brien, 2005), their perceptions of 'paedophiles' (Gavin, 2005) and their views on how 'paedophiles' should be treated by the judicial system (Sprott & Doob, 1997). This treatment has appeared to focus on incarceration and little attention paid to rehabilitation of offenders or whether this is effective in preventing re-offending. Aims: The aims of this research are to explore media constructions of 'paedophiles' focusing on constructions of the 'nature' and 'origins' of 'paedophilia' and tracing implications for the rehabilitation of 'paedophiles'. Method: Print media in the form of newspaper articles were used to examine the research question. A selection of 'popular', 'mid market', and 'quality' newspapers, published over three weeks from 30th January to 18th February 2006 were analysed using discourse analysis (Potter & Wetherell, 1987). This method was used to examine how the media used language to construct 'paedophiles', to identify the functions these constructions performed, and to consider how these functions are achieved (Coyle, 2006). Results: Forty-two newspaper articles were used in the analysis, and the majority of these were found in the 'popular' press, especially 'The Sun'. The main themes that emerged were: the depersonalised construction of the 'paedophile' (with an emphasis on the inherently evil and inhuman nature of the 'paedophile' emphasised); the blaming and positioning of responsibility for offending (emphasising the responsibility of professionals to prevent offending); and the context of child protection and rehabilitation (emphasis placed on custodial sentences rather than rehabilitation). Discussion: The practical and theoretical implications of these findings were discussed (including how the construction of 'paedophiles' might effect their motivation to seek help, and its role on the maintenance of 'paedophilic' behaviour), as well as the limitations of the study.
References


MAJOR RESEARCH PROJECT

A RESEARCH STUDY INTO THE EFFECT OF MIDWIFE ‘DEBRIEFING’ ON THE PSYCHOLOGICAL WELLBEING OF WOMEN AFTER BIRTH

Year 3
November 2007
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ABSTRACT

Aim: According to the NICE Guidelines for Antenatal and Postnatal Mental Health (NICE; 2007a), there is insufficient evidence upon which to base the provision of effective postnatal mental health services. However, most hospitals in the UK provide a midwife debriefing service for women who have had what they and/or healthcare professionals perceive to be a difficult or traumatic birth experience (Ayers et al., 2006). This research aims to explore the effect of midwife debriefing on the psychological wellbeing of such women after birth.

Design: A prospective, naturalistic, mixed between and within subjects design was used to compare change in women who had debriefing with those who did not.

Setting: Maternity departments of two hospitals in southeast England, which offer a midwife debriefing service.

Participants: 23 debriefing group and 61 comparison group women completed demographic, pregnancy and childbirth questionnaires and ‘pre’ outcome measures; 18 debriefing group and 50 comparison group women also completed ‘post’ outcome measures.

Main outcome measures: Edinburgh Postnatal Depression Scale, PTSD Symptom Scale – Self Report, Posttraumatic Cognitions Inventory and Significant Others Scale.

Results: A profile of the women who attended debriefing was obtained. The debriefing group experienced a significantly greater improvement in symptoms of postnatal depression but not in those of postnatal PTSD compared to women in the comparison group. The groups did not differ in change to trauma related appraisals. Women in the debriefing group were significantly less satisfied with their emotional and practical social support than those in the comparison group.

Conclusions: Recommendations for clinical practice include routine screening following childbirth to identify women with symptoms of postnatal PTSD and/or depression, who should be encouraged to access debriefing when they are ready to focus on their own needs, rather than those of their baby. Debriefing services should develop routes to refer such women on to specialist trauma services, counselling or postnatal depression groups as necessary.
INTRODUCTION

Childbirth and the provision of maternity services are currently highly topical issues. This year the Department of Health issued 'Making it better: for mother and baby' (Shribman, 2007), a document which proposes the redesign of maternity services. Meanwhile the National Institute for Health and Clinical Excellence (NICE; 2007a) issued guidance on clinical management and service provision for antenatal and postnatal mental health. These guidelines (pp.69) refer to 'the paucity of research' into the incidence and prevalence of postnatal mental health disorders, and insufficient evidence upon which to base the provision of effective services.

In their lifetime around 80% of women in England and Wales have at least one baby (National Statistics Online). In England and Wales around 1,750 women give birth every day; in 2005, 639,627 women gave birth (Office of National Statistics, 2006; pp.7). However, Smith and Mitchell (1996) note that whilst childbirth is a common occurrence for staff within maternity services, for mothers, who may do this only once or twice, it is a unique and important experience.

NHS ANTENATAL AND POSTNATAL CARE

Pregnant women are referred to antenatal services by their GP (Shribman, 2007). According to the National Collaborating Centre for Women's and Children's Health (2003), healthy pregnant women should be offered an initial antenatal appointment before the twelfth week of their pregnancy during which they are provided with information to enable them to make informed decisions about their care. Appointments continue throughout the pregnancy to monitor the health of the woman and her growing foetus; screening tests are offered and further information provided as necessary.

According to the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2004), following their return home after the birth of their baby women receive community based postnatal care, and are usually discharged from the care of the community midwife when their baby is 10 to 14 days old. Discharge from maternity care usually occurs when the baby is six to eight weeks old, following the mother's postnatal examination; the health visitor then becomes responsible for care of mother and baby.
POSSIBLE PSYCHOLOGICAL CONSEQUENCES OF CHILDBIRTH

The birth of a baby can be 'a time of happiness and excitement' Buultjens (2007, pp.77); accordingly Figes (1998, pp.85) describes having felt '... wonder, amazement, contentment ...' following childbirth. However, Murphy et al. (2003; pp.1) comment 'although childbirth is often a joyful time and can have a positive impact on a women's life ... it can have a detrimental effect on her emotional wellbeing'. According to Osofsky (1985, pp.313), 'even psychologically well-adjusted women, who have desired to become mothers, may experience considerable psychological upheavals during pregnancy and adjusting to the new baby'. Indeed, Figes (1998, pp.1) recalls being 'unprepared for the great landslide of physical, sensory, emotional and psychological upheaval that motherhood brings'.

In the postnatal period it is normal for there to be changes in aspects of a woman's mental state and functioning including 'sleep disturbance, tiredness, loss of libido and anxious thoughts about the infant' (NICE, 2007a; pp.73). Ayers et al. (2006; pp.157) note that 'difficult birth experiences can affect women's psychological health', although most women do not develop clinically significant psychological problems as a result. Littlewood and McHugh (1997, pp.68) describe pregnancy and childbirth as 'highly stressful life events' and argue 'some degree of maternal distress is almost universally present amongst women who have recently given birth'. Similarly, Buultjens and Liamputtong (2007, pp.87) describe transition to motherhood as 'intensely stressful' and argue that emotional reactions to motherhood should be normalised. So for women to experience some distress following childbirth appears to be the norm.

The 'baby blues' are common in the postnatal period, beginning 3-4 days after birth and lasting up to two weeks before remitting spontaneously. Reported prevalence rates vary between 30-75% (Robertson et al., 2004).

Reported prevalence rates for postnatal depression (PND) range from 8% (Cox et al., 1993) to 24% (Small et al., 2000). Medical explanations for its onset are considered by Littlewood and McHugh (1997); they note Dalton (1980,1984,1985) proposed changes in progesterone levels following delivery may be responsible, whereas McIntosh (1986) suggested hormonal changes merely predispose vulnerable women to PND. Buultjens and Liamputtong (2007, pp.78) argue for the impact of 'emotional and physical exhaustion', lack of preparation for the degree of life-change, and contradictions associated with the role of motherhood, which is
Research Dossier: Major research project

simultaneously idealised and undervalued within western society. Littlewood and McHugh (1997, pp.75) argue PND is 'a realistic response to the life event of giving birth and the stress associated with the role of mother'. Oakley (1993) suggests feelings of depression after childbirth are associated with unanticipated losses including that of status, independence and identity. According to Podkolinski (1998, pp211), Nicolson (1990) concluded that the sadness associated with PND can be normalised by understanding it using a model of loss and bereavement to conceptualise it as a grief reaction to such losses. Using such a model this grief can be seen as 'an essential process in the return to an equilibrium'.

Some symptoms of postnatal post traumatic stress disorder (PNPTSD) appear to affect up to 30% of women following childbirth (Beck, 2004), although as most women recover spontaneously, this would indicate a traumatic stress response rather than PTSD (Ayers, 2004). Nonetheless, between 1.5% and 6% of postnatal women do meet DSM-IV (American Psychiatric Association; APA, 1994) criteria for post traumatic stress disorder (Beck, 2004). The diagnosis of PTSD and indeed its existence as a psychiatric category have proven controversial. Summerfield (2001) has criticised the subjective nature of the DSM-IV criteria, claiming there is no specified distinction between normal and pathological distress. He also cautions that distress, for example as may be experienced by a woman in respect of her experience of labour, should not be labelled as PTSD, as this inappropriately classifies her as being mentally ill. However, Mezey and Robbins (2001, pp.323) argue that PTSD 'is associated with clinically important distress that transcends ordinary misery and unhappiness' and the symptoms are 'a normal response to an abnormal event rather than a pathological condition'. Lyons (1998, pp.124) warns against framing 'postnatal distress and adjustment in terms of mental illness' and suggests that PNPTSD should be understood as 'describing a type of psychological symptom rather than labelling mothers as suffering from a psychiatric condition'.

Much more rarely, and more seriously, postpartum (or puerperal) psychosis can occur; according to Robertson et al. (2004) prevalence is 1-2 cases per 1000 deliveries, and hospitalization is usually required.

As the 'baby blues' are transitory and postpartum psychosis is so rare, the focus of the current research is on postnatal services available to women who experience symptoms of PNPTSD; it will also consider PND which may co-occur.
The distress associated with symptoms of PNPTSD and PND has been described as a realistic or normal response to childbirth and the transition to motherhood (Littlewood & McHugh, 1997; Mezey & Robbins, 2001), and so the labelling of women who experience such distress as mentally ill is controversial. Bolton and Hill (2003) argue against the categorical nature of such a diagnosis, with its implication that the woman concerned either has or does not have the specified condition(s). If symptoms indicative of both PND and PNPTSD are indeed realistic or normal responses this would imply that they exist on a continuum; Bolton and Hill (2003, pp.255) criticise as ‘arbitrary’ the number and duration of symptoms required to make such diagnoses. However, some women may find it helpful to have such a label for their distress, which may then enable them to access support.

Postnatal Post Traumatic Stress Disorder
Schiraldi (2000, pp.363-364), notes symptoms consistent with a diagnosis of PTSD date back to 1900 B.C., when ‘hysterical reactions’ were reported by Egyptian physicians. Similar descriptions appear in Homer's 'The Odyssey' (8th century B.C.), and are portrayed by Shakespeare (1597) and Samuel Pepys (1600). During World War I the term ‘shell shock’ was adopted to describe the symptoms, and by World War II ‘battle fatigue, combat exhaustion and traumatic neurosis’ were used.

The term Post Traumatic Stress Disorder (PTSD) was first recognised in DSM-III (APA; 1980), since then diagnosis has required that the individual concerned has been exposed to a traumatic stressor. Until DSM-IV was issued however, such a stressor was defined as an event ‘outside the range of usual human experience and that would be markedly distressing to almost anyone’ (DSM-III) and so was applied to experience of wars or natural disasters but not to more everyday events such as road traffic accidents and childbirth. It was not until 1994 when DSM-IV was issued, that the individual’s subjective response to the stressor was specified and the possibility of PTSD as a result of childbirth recognised.

Diagnosis
According to DSM-IV, for PTSD to be diagnosed the individual must have been exposed to a traumatic stressor extreme enough to involve experience of, witnessing of, or being confronted with ‘an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others’ (criterion A1). However, such exposure alone is insufficient, as the individual’s subjective
response is critical when making a diagnosis. The response must have ‘involved intense fear, helplessness, or horror’ (criterion A2), and following such an experience the event should be re-experienced for example through ‘recurrent and intrusive distressing recollections’, ‘recurrent distressing dreams’ and/or ‘acting or feeling as if the dream were recurring’ (criterion B). Other criteria relate to the ‘persistent avoidance of stimuli associated with the trauma’ and ‘numbing’ (criterion C), and ‘increased arousal’ (criterion D). The diagnosis of PTSD requires at least one re-experiencing symptom, three avoidance symptoms and two arousal symptoms. Symptoms must have been present for more than a month (criterion E) and cause ‘clinically significant distress or impairment in social, occupational or other areas of functioning’ (criterion F). Diagnosis is specified as ‘acute’ if symptoms have been present for less than three months and ‘chronic’ if present for longer.

Childbirth as a traumatic stressor

As already stated, the individual’s subjective response to the stressor, in this case during childbirth, is pertinent to the diagnosis of PTSD. Although childbirth is not in itself an abnormal event, certain aspects of childbirth may be perceived as abnormal and therefore potentially act as traumatic stressors for some women. Schreiber and Galai-Gat (1993: pp107) note, ‘severe uncontrolled pain, a prolonged state of acute anxiety, uncertainty regarding the immediate future, loss of control ... may play an important role in the formation of PTSD’. To clarify how such factors may become features of some women’s birth experience, it will first be helpful to consider childbirth in detail.

Labour

Van de Pol et al. (2006) describe the process of childbirth as ‘a substantial physical and emotional endeavour’. Childbirth is a painful experience for the majority of women, indeed according to Findley and Chamberlain (1999; pp.927) ‘most women think pain is going to be a major part of giving birth’. Cassidy (2007, pp.79) comments 'labour can cause the most severe pain a women will feel'.

There are three stages to labour. In the first stage the women’s cervix dilates from 0cm to 10cm, which can take approximately 12-14 hours for a first labour (Stoppard, 2000). In the second stage the uterus contracts and eventually pushes the baby out of the women’s body, stretching the vagina and perineum; this can take up to two hours (Stoppard, 2000). In the third stage further contractions expel the placenta
from the uterus, which then contracts. Pain is associated with the dilation of the 
cervix, the contraction of the uterus and the stretching of the vagina and perineum.

If labour does not start naturally it can be induced artificially, for example if the baby 
is sufficiently overdue. Induction is associated with stronger contractions and 
therefore more intense pain.

**Pain relief**
Due to the painful nature of childbirth, there are many forms of pain relief available to 
women in labour.

In the early stages of labour Transcutaneous Electrical Nerve Stimulation (TENS) 
may be used. TENS is self-administered via pads attached to the women's back and 
provides pulses of electricity which can override pain signals from the uterus and 
cervix and also stimulate the production of endorphins which act as natural 
painkillers. Findlay and Chamberlain (1999) found that TENS is used by about 5.5% 
of women in labour, of who a quarter described the pain relief obtained as 'very 
good' although a quarter found it unhelpful. In their systematic review of randomised 
control trials (RCTs), Carroll *et al.* (1997, pp.169) found 'no compelling evidence' of 
any analgesic effect provided by TENS during labour.

Gas and air (Entonox) is a mixture of oxygen and nitrous oxide which is self-
administered to reduce the pain of contractions. According to Findlay and 
Chamberlain (1999), this is used by 60% of women, 85% of whom find it helpful.

Pain relieving injections of opioids, such as pethidine, can be given during the first 
stage of labour; this can take 20 minutes to work (Stoppard 2000). Pethidine does 
ot totally remove pain and can affect the baby's breathing or make it sleepy if given 
too near the time of birth.

An epidural is an anaesthetic injection into the spine which numbs the nerves of the 
uterus and cervix so contractions cannot be felt, however it is allowed to wear off in 
order to enable the women to push the baby out in the second stage of labour. 
Longer labour and an increased likelihood of assisted delivery are associated with 
the use of epidurals. Findlay and Chamberlain (1999), (pp.928), report 'over 90% of 
women found it to be good or very good and 85% would choose it again'.

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So, the pain of childbirth can be severe, and there are methods available to help women manage that pain, but can the pain always be controlled? Carroll et al. (1997) note the use of TENS does not have to be recorded in midwifery notes; therefore there are no official statistics for how frequently this method is used. However as maternity TENS machines can be rented from national chains of high street chemists in the UK it seems likely many women use this method despite evidence that it may be ineffective. Pethidine can take 20 minutes to work, perhaps leaving the woman with a sense that her pain is not controlled. Epidurals appear to be popular, but when allowed to wear off to enable the women to push out the baby, a period of sudden intense pain will be experienced.

**Delivery**

Most babies are born vaginally (Royal College of Obstetricians and Gynaecologists, 2001). If a woman is unable to push the baby out unaided delivery may be assisted using forceps or ventouse. Either forceps are fitted around the baby’s head, or the ventouse, a silicone suction cap, is attached to the baby’s head to enable the baby to be pulled out of the vagina aided by the woman’s contractions.

Vaginal delivery can result in tears to the woman’s perineum. If this is likely to happen, for example if forceps are used to facilitate the delivery, then an episiotomy is performed. This is a surgical incision made under local anaesthetic to enlarge the vaginal opening, which is stitched back together after delivery. Stoppard (2000) notes the episiotomy wound initially gets more painful as the skin in this delicate area swells and the stitches become tighter.

If a vaginal delivery is not possible the baby will be delivered by Caesarean section, a major surgical operation in which a cut is made into the women’s abdomen and uterus, and the baby is removed. The operation can be conducted while the woman is under general, or more frequently local, anaesthetic. Caesareans can be ‘elective’, for example if the position of the baby in the uterus indicates successful vaginal delivery is not possible, or ‘emergency’ if complications develop during pregnancy or labour, for example if the baby becomes physically distressed. According to the website of the public information service BirthChoiceUK (www.birthchoiceuk.com), 23% of births in England and Wales during 2006 were by Caesarean section: 9% of births were elective, and 14% emergency Caesareans.
According to van de Pol et al. (2006), mode of delivery can have psychological consequences, with both emergency Caesarean section and instrumental vaginal delivery being implicated in greater emotional distress in the mother compared to normal vaginal delivery. Circumstances necessitating an emergency Caesarean section may result in acute anxiety, uncertainty regarding the immediate future and a sense of loss of control, especially if it is thought the baby’s life is at risk. In addition, women may experience the cutting of their abdomen to facilitate a Caesarean or of their genitals for the episiotomy as a threat to their physical integrity.

Axe (2000) suggests negative memories of aspects of giving birth, including the quality of care received or the people involved in the experience can subsequently affect a women’s emotional and psychological wellbeing. She comments that perceptions of the event of childbirth can be distorted by tiredness, emotions, and the drugs received in labour. However, Priest et al. (2003) note 'stress disorders' can occur whether or not labour was complicated or prolonged, or delivery was operative, acknowledging the critical role of women’s subjective experiences in the aetiology of this disorder. An important aspect is that a woman may perceive her birth experience to have been traumatic even though the delivery is perceived as normal by professionals (Axe, 2000).

**Psychological models of PTSD**

Various psychological models have been used to explain the aetiology of PTSD. According to Dalgleish (1999), Horowitz (1973, 1976, 1979, 1986) suggested a theory which utilises aspects of psychodynamic theory to explain that the traumatic event is kept from consciousness by defence mechanisms which periodically break down, allowing the event to seep through into consciousness in the form of flashbacks and other re-experiencing symptoms. However, as Dalgleish (1999) points out, this model fails to explain why some individuals who experience traumatic events do not develop PTSD but others do.

Dalgleish (1999) argues that the cognitive approach best accounts for the variety of factors associated with the occurrence of PTSD. Cognitive theories focus on different facets of the discrepancy between an individual’s pre-existing mental representations about themselves, the world and others, and new trauma-related information received from the traumatic event which appears to contradict them.
Ehlers and Clark (2000) have proposed a cognitive model of PTSD which suggests the persistence of PTSD symptoms can be explained by an excessively negative appraisal of the trauma and/or its consequences. Such negative appraisals are thought to lead to a sense of serious, current threat which in turn produces the symptoms of re-experiencing, arousal and anxiety associated with PTSD.

Ehlers and Clark (2000) comment that PTSD is classified as an anxiety disorder and such disorders are usually explained by cognitive models as relating to an impending threat rather than one which has already been experienced. They argue that after exposure to a traumatic event some people experience a sense of current threat or danger but others do not because of individual differences in how the event and/or the consequences of the event are appraised, and in how it is integrated into autobiographical memory.

Problematic appraisals can be internal, relating to the individual's opinion of themselves, and/or external, relating to their opinion of the world. For example, the individual may appraise themselves as more vulnerable, and the world as less safe, than previously; both such appraisals may lead to a sense of current threat. Similarly, the individual's appraisal of their consequent symptoms, for example flashbacks, may lead them to believe they will never recover.

Ehlers and Clark (2000) argue the way an event is integrated into autobiographical memory affects how it is re-experienced. Thus, some aspects of the event may be apparently inaccessible whereas others are re-experienced involuntarily as nightmares and/or flashbacks. Ehlers and Clark (2000) comment that in attempting to suppress thoughts about a traumatic event, paradoxically the individual may increase the likelihood of experiences such as flashbacks. These re-experiencing symptoms then endorse the perception of serious current threat.

Ehlers and Clark (2000) propose this model leads to various implications for treatment, including the use of education about hospital procedures to modify incorrect appraisals of trauma relating to them.

and PTSD symptoms, within a few days of the trauma occurring (acute stage) and three and twelve months later. They found acute stage cognitions and those measured three months after the traumatic event were predictive of PTSD symptoms assessed one year after the event. Negative self-appraisal was identified as being most predictive of subsequent PTSD symptoms. In some participants this measure increased over time, which O’Donnell et al. (2007) propose may be due to a feedback loop in which negative self-appraisal leads to an increase in perceived current threat, which then leads to an elevation of anxiety symptoms. Negative cognitions about the world were less predictive of subsequent PTSD symptoms; O’Donnell et al. (2007) suggest this may be because the population they assessed were predominantly survivors of motor vehicle accidents whereas a study of survivors of deliberate assault may have produced a different outcome. Elevated attributions of self blame were associated with fewer PTSD symptoms; O’Donnell et al. (2007) postulate this may be due to a renewed sense of self-control, which then reduces the sense of ongoing threat.

Foa et al. (1999; pp.303) comment ‘not all trauma victims develop PTSD, many who initially develop PTSD recover [spontaneously] over time’ leading to theorising about the role of individual differences in the perception of the trauma and its sequelae in the development of trauma related psychopathology. Various risk factors associated with the development of PTSD have been identified; in his overview of current understanding of PTSD, Bisson (2007) noted pre-traumatic factors including female sex, lower socioeconomic status, lack of education and racial minority status. He also identified peri-traumatic factors include severity of trauma and threat to life, and post-traumatic factors include perceived lack of social support and subsequent life stress.

The NICE guidelines for PTSD (NICE, 2005) recommend watchful waiting for individuals with mild symptoms present for under four weeks. Trauma-focussed cognitive behavioural therapy (CBT) is recommended for individuals with severe PTSD or severe post-traumatic symptoms present for less than four weeks and for those whose symptoms are not severe but have been present for up to three months. Trauma-focussed CBT is also recommended for symptoms present longer than three months, as is eye movement desensitisation and reprocessing (EMDR). Medication is recommended to manage sleep disturbance during the acute phase of PTSD.
Co-occurrence of PTSD and depression

O’Donnell *et al.* (2004) note PTSD is often accompanied by other psychiatric conditions, with major depression being the most common. They suggest this is due to a ‘shared vulnerability with similar predictive variables’ (pp.1390). Creamer *et al.* (2001) found 65% of women with a diagnosis of PTSD also had a major depressive episode. The NICE Guidelines for PTSD state that in such a case the PTSD should be treated first, as if this is successful depression will often improve. However if the depression is so severe as to make treatment of the PTSD difficult, the depression should be addressed first.

Postnatal Depression

Patel *et al.* (2005, pp.1) argue the timing of onset of PND differentiates it from depression experienced at other times of life. According to Shakespeare *et al.* (2003) the majority of cases develop within three months of childbirth and incidence peaks at four to six weeks. Cox *et al.* (1993) found that although the prevalence of depression in women postnatally is similar to that in women in the general population, the rate of onset of depression in this group at this time is three times that of women in the general population.

The NICE Guidelines for Antenatal and Postnatal care (NICE, 2007a) warn that the term ‘postnatal depression’ can be misused in clinical settings, and specifically that this term can be used as ‘a label for any mental illness occurring postnatally’ (pp.72), which can mean that other serious mental health problems are overlooked. They comment that an over-emphasis on PND can mean services are not developed to focus on depression occurring antenatally, and other disorders occurring antenatally and postnatally. The guidelines also express concern that use of the term ‘postnatal depression’ can imply there is a difference between depression experienced postnatally and that occurring at other times, perhaps leading to expectations from clinicians or the women concerned that the symptoms are due solely to breastfeeding, sleep deprivation or hormonal changes. The guidelines (pp.72) therefore recommend ‘the usual diagnostic guidelines for each condition, such as those contained in ICD-10 [World Health Organisation, 1994] and DSM-IV be followed’.

The DSM-IV diagnostic criteria for a major depressive episode requires the presence of five or more symptoms for two weeks, including depressed mood and/or marked
diminished interest or pleasure in all or almost all activities most of the day, nearly every day. Other symptoms include significant weight loss or gain, decrease or increase in appetite, sleep difficulties, fatigue or loss of energy, diminished ability to concentrate, feelings of worthlessness and recurrent thoughts of death or suicide. The diagnosis of a minor depressive episode requires the presence of two to four of these symptoms for two weeks, including depressed mood and/or marked diminished interest or pleasure in all or almost all activities most of the day, nearly every day. In both cases the symptoms must cause significant distress or impairment in social, occupational or other important areas of functioning. Cox (2004) notes that according to DSM-IV the specifier 'with postpartum onset' should be used for onset within 4 weeks postnatally, whereas ICD-10 specifies onset within 6 weeks for 'disorders associated with the puerperium'. However, Howard (2007) notes 'recently [up to] 3 months postpartum was suggested as a useful clinical definition'.

Several risk factors for PND have been proposed. The systematic review of recent literature conducted by Robertson et al. (2004) identified that a previous history of depression, depression, anxiety or stressful life events experienced during pregnancy and low levels of social support were the strongest predictors of PND.

The NICE Guidelines for Depression (NICE, 2007b) recommend watchful waiting followed by exercise and CBT based guided self-help if thought necessary for milder cases; antidepressant medication and CBT or interpersonal therapy (IPT) are recommended if the individual does not respond. Antidepressant medication is recommended for moderate cases and is prioritised over psychological interventions. CBT and IPT are recommended for moderate to severe depression.

SCREENING FOR POSTNATAL DISTRESS

Dermott et al. (2006, pp.28), note that as part of their routine antenatal care women should be informed within three days of giving birth about 'normal patterns of emotional changes in the postnatal period', and reassured that they usually 'resolve within 10-14 days'. However, Epperson (1999) argues that 'first-time mothers may not recognise that what they are experiencing is not within the norm', indicating women may go on to experience PND and/or PNPTSD but be unaware of what it is. Currently women are often screened for PND using the Edinburgh Postnatal Depression Scale (EPDS; Cox, 1987), which is a ten item self report scale. However the NICE Guidelines for Depression (NICE, 2007b) suggest using two questions to
screen for depression: ‘during the past month, have you been bothered by feeling down, depressed or hopeless?’ and ‘during the past month, have you been bothered by having little interest or pleasure in doing things?’ (Whooley et al., 1997). The NICE Guidelines for Antenatal and Postnatal Mental Health call for a validation study to be conducted using these questions to screen for PND; they do not mention screening for trauma symptoms. Shakespeare et al. (2003) note that some women find PND screening unacceptable because of the perceived intrusiveness of the procedure, the stigma of being diagnosed with PND, and concerns that they might lose their baby as a result.

A possible consequence of the current focus of NHS screening for PND is that trauma symptoms may not be asked about. Potentially a diagnosis of depression may be made and the woman treated accordingly. If the condition is treated using drugs the symptoms may subside, the treatment be assumed effective and the drug discontinued. Meanwhile the underlying trauma remains unidentified and untreated and may therefore re-emerge. Or, as Shakespeare et al. (2003) comment, an apparently ‘normal’ PND screening result might make it hard for the women concerned to discuss other distress, for example that associated with PNPTSD.

CONSEQUENCES OF PND AND PNPTSD

Both PND and PNPTSD have been shown to have serious repercussions for the women affected, including in bonding with their child (Hofberg & Ward, 2003; Murray & Cooper, 1997). Secondary tokophobia (fear of childbirth), and demand for abortion in order to avoid another labour have also been associated with PNPTSD (Hofberg & Ward, 2003). Nulman et al. (2002; pp.1889) concluded that depression in mothers is associated with ‘less cognitive and language development in their children’ compared to the children of women whose symptoms were treated with antidepressants.

THE ROLE OF SOCIAL SUPPORT

Lack of social support has been identified as a risk factor for the development of both PTSD and depression; it was found to be the strongest predictor of the development of PTSD in a meta-analysis of 77 articles (Brewin et al., 2000). Brugha et al. (1998) found depression after childbirth could be predicted from lack of satisfaction with support from others. Robertson (2004) found perceived social isolation (i.e. lack of structural social support) was predictive of PND.
Orr (2004, pp.843) describes social support as 'resources and aid derived from one's social relationships'. Social support has been conceptualised in various ways, including as having structural and functional aspects; Cohen and Syme (1985) suggest 'structural' social support refers to the actual existence of social relationships, whereas 'functional' social support refers to resources provided by those relationships. Leahy Warren (2005, pp.481) points out these two elements are 'inextricably linked'. Power et al. (1988) argue the functional aspects of relationships include emotional and practical support, both of which may be particularly crucial during pregnancy and whilst caring for a new baby, a time when women experience changes in their roles and responsibilities, and also have to adapt to other social, psychological and physical changes (Tarkka & Paunonen, 1996).

Orr (2004) found low levels of social support during pregnancy were associated with low birth weight and preterm birth. In a study of social support and confidence in infant care in first time mothers, Leahy Warren (2005) highlights the importance of functional support in helping women to adapt to motherhood. She found the woman's husband or partner, her mother, and public health nurses (health visitors) were the main sources of such support.

The importance of social support for women who have experienced a traumatic birth and those who have symptoms of depression is recognised by the NICE Guidelines for Antenatal and Postnatal Mental Health (NICE, 2007a, pp.161). The former 'should be encouraged to make use of natural support systems available from family and friends'. The latter should be offered social support during pregnancy or postnatally, which 'may consist of regular informal individual or group based support'.

DEBRIEFING

Ayers (2006) notes debriefing has its origins in critical incident stress debriefing (CISD), which was originally proposed by Mitchell (1983) as a formal structured single session intervention to be conducted with groups of people shortly after they have experienced a potentially traumatising event. The aim of CISD is the prevention of PTSD onset, it involves detailed discussion of the event, and its use is controversial. In their review of the literature Rose et al. (2002) were unable to find evidence that CISD reduces the risk of developing PTSD; indeed two studies they reviewed implied CISD may increase the risk, perhaps by re-traumatisation. Accordingly, the NICE Guidelines for PTSD (pp.16) state 'it is unlikely that a single
session of a psychological intervention will be helpful'; they go on to declare 'brief single-session interventions (often referred to as debriefing) that focus on the traumatic incident should not be routine practice' (their emphasis). Thus it would appear the provision of such a service for PTSD is contrary to these guidelines. Furthermore, Rose et al. (2002) found no evidence that single session debriefing reduced depression.

Midwife debriefing after childbirth
Concordant with the NICE Guidelines for PTSD (2005), those recently issued for antenatal and postnatal mental health (NICE, 2007a) specify single-session formal debriefing focused on the birth should not be offered to women who have experienced a traumatic birth. Instead it is suggested maternity staff and other healthcare professionals support women who wish to talk about their experience and encourage them to make use of support from family and friends. The guidelines also contain the reminder that the guidance provided 'does not ... override the individual responsibility of healthcare professionals to make appropriate decisions in the circumstances of the individual patient ...' (pp.37).

Most hospitals in the UK provide a service to which women who had what they and/or healthcare professionals perceive to be a difficult or traumatic birth may be referred, which enables them to discuss aspects of that experience informally with a midwife. Ayers et al. (2006, pp.157) found such a service was offered by 78% of hospital maternity units as an intervention 'for women who have symptoms of traumatic stress after birth'. These services have been described as 'birth afterthoughts', (Charles & Curtis, 1994), 'labour debriefing' (Axe, 2000), 'listening visits' (Clement 1995), 'midwifery debriefing' (Madden, 2002), 'non directive counselling' (Gamble et al., 2002), 'postnatal debriefing' (Ayers et al., 2006) and 'postpartum counselling' (Gamble & Creedy, 2004). Gamble et al. (2002) note the term 'debriefing' has been used in the literature to describe a variety of interventions, from formally structured CISD to a 'range of post-birth discussions' (pp.74). Thus the term debriefing will be used hereafter to refer to all such services.

It is likely the exact content of these interventions varies, although precise details are often lacking in the literature. However, a common feature seems to be that the midwife has access to the woman's maternity records which contain details of her pregnancy, labour and care. These records 'provide a chronology of all decisions,
discussions and outcomes of care' (Smith & Mitchell, 1996, pp.584) and can therefore be used by the midwife to explain procedures and answer questions about the event of childbirth. The focus of sessions is predominantly on 'medical events and explanations' (Ayers et al., 2006, pp.158). In their summary of themes arising in debriefing sessions, Smith and Mitchell (1996) note women mainly asked for information regarding their labour and the early postpartum period; other themes they identified included perceived lack of continuity, outstanding health issues, anxiety about the baby and complaints about the service. It is unclear whether such a session with its focus on childbirth, which may have been perceived by some women as traumatic, constitutes debriefing as discouraged by the NICE guidelines, or whether it provides support to women who wish to talk about their experience as recommended by the guidelines.

Ayers et al. (2006) found that in only 54% of the hospitals from which debriefing services were offered were all women who gave birth routinely informed of the service. In 7% of these hospitals women were informed during pregnancy, in 74% they were informed after birth, and in 19% they were informed both during pregnancy and after giving birth. Smith and Mitchell (1996) note the importance of such a service being offered to all women, irrespective of mode of delivery; of deliveries experienced by women referred to their service, 42% had instrumental deliveries, 35% emergency caesarean sections, 7% elective caesarean sections and 16% had non-instrumental, vaginal deliveries. Axe (2000) comments that following a delivery which is objectively considered traumatic, or a still birth or neonatal death, women are often offered debriefing, whilst those whose delivery was apparently 'normal' may be offered 'non-structured and inconsistent' support (pp.627). However a woman may consider her birth experience to have been traumatic even though the delivery was perceived as 'normal' by professionals. She argues all women should be made aware of the availability of debriefing services antenatally, in recognition of the role of the individual's subjective response to the event of childbirth in the aetiology of symptoms indicative of PNPTSD.

Small et al. (2000) conducted an RCT of midwife debriefing offered to women following an operative delivery. They found 94% of women rated postnatal debriefing as 'helpful' or 'very helpful', although subsequently there was no difference in improvement in depression between women who had debriefing and those allocated to standard care. So postnatal debriefing appears to have high face validity and
client satisfaction. However, as Rose et al. (2002) warn, this alone is insufficient to warrant the provision of such an intervention in an organisation such as the NHS which requires evidence-based practice.

Priest et al. (2003) also found no significant differences between women who received postnatal debriefing and their comparison group in any outcome measure including depression. Gamble et al. (2002) comment in their literature review that despite debriefing being designed to reduce trauma symptoms and prevent PNPTSD, the studies reviewed used outcome measures related to depression not trauma. They note the frequent co-occurrence of depression and PTSD and warn against an assumption that debriefing may not reduce symptoms of trauma purely because it does not appear to reduce those of depression. Gamble et al. (2002, pp.78) recommend trauma symptoms should be a ‘measured maternal outcome in studies investigating the use of debriefing

The studies by Small et al. (2000) and Priest et al. (2003) considered debriefing which occurred when women were still in hospital following delivery; it is possible this was too soon after the event for it to have been beneficial. The women may still have been too distressed or numbed to have been receptive to the debriefing, as has been suggested by Hobbs et al. (1996). Or, as Axe (2000) proposes, immediately following childbirth perhaps a woman’s attention is on caring for her new baby and developing the skills necessary to do so, rather than on her feelings about her labour experience.

Smith and Mitchell (1996) found most referrals were made over four weeks after the referred woman gave birth. However as their study did not report psychological outcome measures, it is unclear whether rates of morbidity were reduced by a delayed intervention.

Little is known about the demographics of women who attend debriefing and how they differ from women who do not attend; where such information has been reported, for example by Small et al. (2000), it is within the context of a RCT.

Despite the evidence regarding the importance of emotional and practical social support highlighted previously, it remains unclear whether women who are dissatisfied with this are any more likely to be referred for debriefing than those who
are satisfied with their social support. In RCTs women are allocated at random to debriefing or standard care; other studies have considered women who accessed debriefing at some point after giving birth but did not compare them with women who did not access debriefing. Therefore it has not been possible to consider the role of satisfaction with social support for women who seek or are referred to such a service compared to those who do not.

The NHS, with its emphasis on evidence based practice, appears to endorse the provision of debriefing services, about which the little available evidence is either inconclusive or controversial. According to Ayers et al. (2006), over 70 percent of litigation in the NHS results from problems with maternity services. As Ayers et al. (2006) speculate, this may lead to pressure on hospitals to make psychological support available postnatally in an attempt to reduce litigation, as well as to improve the maternity care they provide. In their study of a midwife debriefing service, Smith and Mitchell (1996 pp.581) found although there were grounds for potential complaint about the care received by 54% of the women seen by the service, none went on to make official complaints. They conclude ‘debriefing after childbirth can clearly be utilised as a risk management tool’, thus perhaps suggesting women be offered debriefing as a way of reducing the risk of litigation. Might the avoidance of litigation also explain why PNPTSD is not routinely screened for within the NHS when PND is? The identification of PND is unlikely to lead to litigation but the identification of PNPTSD, with possible implications of this being linked to care provided in labour, might.

SUMMARY AND KNOWLEDGE GAPS
According to the NICE Guidelines for Antenatal and Postnatal Mental Health (NICE, 2007a), there is insufficient evidence on which to base the provision of effective postnatal mental health services. Some women experience a difficult or traumatic birth and develop symptoms indicative of a traumatic stress response or PNPTSD, with which PND may co-occur. Most hospitals in the UK provide a midwife debriefing service for such women (Ayers et al., 2006), so there is a need to expand the evidence base to enhance effective service provision.

Little is known about the demographics, pregnancy and labour experiences, and obstetric history of women who attend debriefing, or how these differ from women who do not attend. Similarly little is know about how these groups differ on measures
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of PNPTSD, PND and appraisal of trauma. Midwife debriefing is an intervention for women who have symptoms of traumatic stress after birth (Ayers et al., 2006), and who may therefore experience PNPTSD; depression is the most common diagnosis to co-occur with PTSD (O'Donnell et al., 2004). It therefore seems likely that women who attend debriefing will score more highly on measures of these than women who do not. A comparison of initial scores for PNPTSD, PND and trauma appraisal would clarify whether women who attend midwife debriefing do differ in these measures from women who do not attend. Such information would enable a profile of women who attend debriefing to be compiled, allowing services to be targeted most appropriately.

Previous RCTs (Priest et al., 2003; Small et al., 2000) have shown no significant differences in improvement in PND between women who received debriefing and those who did not. However, as most women who received debriefing found it helpful, it may be that symptoms of PNPTSD rather than PND are alleviated. Most debriefing referrals are made more than four weeks postnatally (Smith & Mitchell, 1996); however interventions in the RCTs were provided within days of the birth, which may be too soon after the event to have an impact on symptoms (Hobbs et al., 1996). It is not known whether changes in PND would have been identified if the intervention was provided later. A comparison of any changes in symptoms experienced by women who access debriefing when they are ready to with those who do not attend would enable proper evaluation of the effectiveness of this intervention.

According to Ehlers and Clarke's (2000) cognitive model of PTSD, the persistence of PTSD symptoms is due to the excessively negative appraisal of a trauma and/or its consequences. Ehlers and Clark (2000) suggest education about hospital procedures can be used to modify such appraisals relating to them. The focus of debriefing sessions is predominantly on explanations regarding the events of labour and childbirth (Ayers, 2006), which may serve to educate women about their experience and thus reduce such negative appraisals. The comparison of changes in these appraisals in women who access debriefing with those in women who do not would clarify whether this is so.

Lack of social support has been identified as a risk factor in the development of PTSD (Brewin et al., 2000), and lack of satisfaction with support from others has
been identified as predictive of PND (Brugha et al., 1998). Depression is the most common diagnosis to co-occur with PTSD (O'Donnell et al., 2004). Midwife debriefing is an intervention for women who have symptoms of traumatic stress after birth (Ayers et al., 2006), and who may therefore experience PNPTSD, with depression possibly co-occurring. Emotional and practical support are elements of social support that may be particularly crucial during pregnancy and whilst caring for a new baby. The comparison of satisfaction with emotional and practical support in women who access debriefing with that in women who do not would clarify whether there is also a relationship between such satisfaction and referral to debriefing services.

AIMS, OBJECTIVES AND HYPOTHESES

Aim
To explore the effect of midwife debriefing on the psychological wellbeing of women after birth.

Objectives
To obtain a profile of the demographics, pregnancy and labour experiences, obstetric history and initial scores on measures of PNPTSD, PND and negative appraisals about any trauma experienced in childbirth and/or its consequences of women who attend midwife debriefing and explore how the profile compares to that of women who do not attend.

To explore whether the debriefing provided by midwives to women who access the service when they are ready leads to changes in symptoms of PNPTSD and/or PND.

To explore whether midwife debriefing leads to a change in women’s negative appraisals about any trauma they have experienced in childbirth and/or its consequences.

To explore whether women who attend midwife debriefing are less satisfied with the emotional and practical support they receive than women who do not attend.
Hypotheses
Compared to women who do not attend debriefing, those who do will:

1. a. Be significantly more likely to experience symptoms of PNPTSD.
   b. Experience a significantly greater improvement in symptoms of PNPTSD.

2. a. Be significantly more likely to experience symptoms of PND.
   b. Not experience a significantly greater improvement in symptoms of PND.

3. Be significantly more likely to experience symptoms of both PND and PNPTSD.

4. a. Be significantly more likely to experience negative trauma related appraisals regarding labour and childbirth.
   b. Experience a significantly greater reduction in negative trauma related appraisals regarding labour and childbirth.

5. Be significantly less satisfied with the emotional and practical support they receive.
METHOD

Maternity units at two hospitals in southeast England which offer a midwife debriefing service participated in this study; they will be referred to as hospital A and hospital B to maintain confidentiality. Between these hospitals over 6,000 women gave birth in 2005, according to BirthChoiceUK.

MIDWIFE DEBRIEFING SERVICES
As previously stated, midwife debriefing is a service to which women who experience symptoms of traumatic stress after birth may be referred, which enables them to discuss aspects of their childbirth experience. Debriefing is available to women in the geographical area covered by the services regardless of their birth experience, and according to midwives who offer the service, uptake is generally from women who perceive they have had a "difficult" labour. Women are notified of the hospital A service by midwives or health visitors who inform them if they consider they would benefit from the service. They refer the woman directly to the debriefing midwife or give her information so she can initiate contact. Women are notified of the hospital B service by leaflets they receive in antenatal and postnatal packs distributed by the maternity department. Referrals to the debriefing services are made by the women themselves (self-referral) and by midwives and health visitors. At hospital A referrals may also be made by family support workers, hospital managers, or the hospital complaints department following a complaint made by the woman. As the two hospitals have different referral policies, and neither has specified referral criteria, the views and attitudes of individual healthcare professionals may potentially influence referrals to both services.

Once a referral is received the debriefing midwife obtains the woman's maternity records, then telephones to offer an appointment. The debriefing midwife at hospital A sees women in a Surestart community setting; the debriefing midwife at hospital B sees women at hospital B or occasionally another local hospital.

Women who attend debriefing usually receive a one-to-one session lasting between one and two hours; occasionally partners also attend. The session is led by the

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6 An analysis of demographic, pregnancy and labour information relating to women referred to each service will therefore be conducted to clarify any such influence on referrals.
woman; content typically includes aspects of their experience of giving birth and occasionally the antenatal period and future deliveries. As the debriefing midwife has the woman's maternity records which contain information about the antenatal period, labour, the postnatal period and care of the newborn baby, she is able to clarify what happened, answer questions about the medical care provided and explain medical terms. Women are given an opportunity to discuss their experience from their perspective, which the midwife spends time listening to and validating. For the purpose of this study the two hospitals will be treated as providing a similar service to referred women.

Women who use hospital A's service may be offered a follow up session, referred to a women's counselling group or PND group if they or the midwife consider it would be beneficial, and/or given information about support groups such as the Birth Trauma Association. They may also be referred to a postnatal clinic if they have outstanding physical problems, or to managers at the hospital should there be a complaint or outstanding problem that could be investigated further. Women using the hospital A service are invited to telephone the debriefing midwife within two weeks to discuss their feelings after the session. Women who use hospital B's service can telephone the debriefing midwife subsequently if they wish; there are currently no procedures to refer these women on to another service.

ETHICAL APPROVAL

Ethical approval for this study was requested from the Research Ethics Committee (REC) in July 2006. Despite the recruitment protocol being accepted by the REC, subsequent amendments were specified by the Research and Development (R&D) Committee of the NHS Trust which covers hospital B; these amendments are detailed in the procedure section below. Following submission of the required amendments, ethical approval was granted in November 2006 (appendix I). Ethical approval was then requested from the University of Surrey's School of Human Sciences Ethics Committee in November 2006 and granted in December 2006 (appendix II).

RESEARCH AND DEVELOPMENT APPROVAL

Negotiations to obtain R&D approval from the NHS Trust which covers hospital B began in September 2006. Once the amended recruitment protocol was agreed
formal applications were made to the NHS Trusts covering both hospitals in November 2006, and approval obtained from both (appendix III).

**DESIGN**

A naturalistic design, in which women were invited to participate following their referral for debriefing, was used to clarify the intervention's effectiveness. An RCT design, which could have clarified efficacy, was considered but rejected as the randomised allocation of referred women to a waitlist and subsequent delay in treatment was deemed unethical. To assess change in any symptoms of PNPTSD and PND and appraisals of trauma over time, a prospective design was selected. To compare any such changes with those occurring spontaneously a comparison group of women who had recently had babies but not been referred to debriefing was recruited. Questionnaires were used to collect data as a clinical interview, the gold standard for assessing symptomatology, was deemed impractical due to resource constraints.

**Participants**

Debriefing group participants were women who had approached, or accepted the offer of, a midwife debriefing service offered by one of the hospitals. Comparison group participants were women who had recently given birth at one of the hospitals but not requested or been referred to debriefing.

**Sample size**

G*Power (Erdfelder et al, 1996) was used to conduct an a priori power calculation in order to determine the necessary sample size for this study. The power calculation, which utilised Cohen's f, suggested 128 participants (64 debriefing cases and 64 for the comparison group) are required for a medium effect size, which for an F test (ANOVA) is .25. By aiming to recruit a total of 90 women to each group it was hoped around 70 would remain involved at follow up. These figures were calculated under the assumption that 75% would agree to participate and of these 75% would not drop out. It was anticipated these calculations would be conservative: in the study conducted by Priest et al. (2003), 92% of the debriefing group participated in follow-up after two months, and in the study conducted by Small et al. (2000), 86% of women who received standard care returned completed questionnaires six months after giving birth.
Estimates received from the two debriefing services indicated they saw an average of 24 women each month between them, all of whom would be invited to participate if they met the criteria to do so. It was anticipated approximately 18 participants would be recruited into the debriefing group each month, amounting to around 90 women over five months of recruitment.

Inclusion and exclusion criteria

**Inclusion**

Women who gave birth at hospital A or B at least one month previously were eligible to participate. The time delay was employed to enable any symptoms of the 'baby blues' to subside, and because the DSM-IV criteria for PTSD requires trauma symptoms to have been present for more than one month.

**Exclusion**

Young women aged 17 years or under were excluded as the questionnaires used were validated on an adult population. Women who were unable to read and write in English were also excluded as the outcome measures are questionnaires written in English, and most were only validated on an English speaking population. Although desirable there were no funds available to meet the costs of translation or interpreting.

**MEASURES**

The questionnaires used in this study are widely used, validated and reliable self-report measures and therefore unlikely to result in distress for participants. However, as it was possible some women might become distressed by completing questionnaires about their experience of giving birth, the information sheet provided (see appendices IV and V) included details of help-lines and suggested other sources of support they could access if necessary.

As participants would probably be caring for babies it was deemed essential completion time was as brief as possible. The questionnaire booklets were piloted on a convenience sample of four mothers of babies to identify any ambiguities or difficulties, and ascertain the completion time. No ambiguities or difficulties were identified; pilot timings reported were 14 minutes, 'easily done in 20 minutes', 27 minutes and 30 minutes. It was therefore anticipated that the questionnaire booklet
would take participants 20-30 minutes to complete. Details of the questionnaires are as follows:

Pre questionnaires

Demographic and Pregnancy Questionnaire (appendix VI):

In accordance with the first objective of obtaining a profile of the women who attended debriefing, participants were asked for demographic information regarding their age, ethnicity, marital status, living arrangements, education and occupation. They were also asked about their experience of pregnancy, labour and delivery, their baby’s current age, and whether they had been referred to midwife debriefing. From this information scores were derived for ‘total analgesia’, and ‘professional support’ and ‘personal support’ in labour.

The ‘total analgesia’ score was calculated by allocating a score to each type of analgesia and adding together all that were used by a participant. These scores were suggested by Clement et al. (1999), who developed them from mean ratings obtained from over 1,700 women postnatally, who were asked to rate each they had experienced, as a medical procedure, on a scale of 0-10 (Table 1).

Table 1: Analgesia scores

<table>
<thead>
<tr>
<th>Analgesia</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>TENS</td>
<td>2</td>
</tr>
<tr>
<td>Gas and air</td>
<td>3</td>
</tr>
<tr>
<td>Pain relieving injection (i.e. pethidine)</td>
<td>5</td>
</tr>
<tr>
<td>Epidural/spinal block</td>
<td>8</td>
</tr>
<tr>
<td>General anaesthetic</td>
<td>8</td>
</tr>
</tbody>
</table>

So a woman who used only gas and air would score ‘3’, whereas one who also had an epidural would score ‘11’.

The ‘professional support’ score was obtained by summing the number of professionals (midwives, doctors and doulas) reported by the participant as having supported her during labour; if ‘more than one midwife’ was specified this was scored as ‘2’. The ‘personal support’ score was the total number of partner, friends and relatives reported by the participant as having supported her.
Participants were also asked about their obstetric history including any previous live births, miscarriages, still births and abortions, and whether they had been referred to debriefing before.

**Thoughts and Feelings Questionnaire (appendix VII):**

Measures relating to the remaining objectives were combined into a ‘Thoughts and Feelings Questionnaire’. Where possible, measures with established reliability, validity and norms obtained from obstetric samples were selected, as recommended by Ayers (2001b).

Two measures were used to obtain a baseline profile of symptoms of PNPTSD and PND, and to explore whether midwife debriefing leads to changes in these, in accordance with the second objective of the study.

Several general measures of depression were considered but rejected as they have been found inadequate with this client group. For example, the depression scale of the Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983) has poor sensitivity with postpartum women (65%; Ayers, 2001a), whereas the Beck Depression Inventory (Beck at al., 1961) lacks specificity with this population (70%; Brockington, 1996). The **Edinburgh Postnatal Depression Scale** (EPDS; Cox *et al.*, 1987), a 10 item self-report scale widely used as a screening instrument for PND, was therefore selected. The EPDS was developed to take into account the fact that some symptoms which might otherwise have been classified as indicators of depression can also be directly related to the postnatal period, for example disturbance in appetite or change in bodyweight. The authors suggest the EPDS may be used in treatment studies of PND in mothers living in the community, and it is recommended by the NICE Guidelines for Antenatal and Postnatal Mental Health (2007a) for assessment of depression postnatally and monitoring of outcomes. Participants are asked to select which of four responses to a prompt question comes closest to describing how they have felt in the previous seven days. Potential scores on the EPDS range from 0-30; the higher the score, the greater the level of depressive symptoms experienced. Cox *et al.* (1987) recommend cut-off scores of >9 for possible depression and >12 for probable depression. Cox *et al.* (1987) report the EPDS has satisfactory validity (Cronbach’s alpha 0.87), reliability (split-half
reliability 0.88), sensitivity (86%) and specificity (78%), and is sensitive to changes in depression over time.

The Impact of Events Scale (Horowitz, 1979) is commonly used to assess changes in trauma related symptoms, but as Rose et al. (2002) note, it has rarely been used in obstetric studies. The PTSD Symptom Scale - Self Report (PSS-SR; Foa et al. 1993), which has previously been used to identify trauma symptoms following childbirth (Ayers and Pickering, 2001; Creedy et al., 2000) and measure changes in trauma symptoms in women (Foa & Rauch, 2004) was therefore selected. The PSS-SR contains 17 items and was developed to assess the presence and severity of PTSD symptom clusters relating to re-experiencing (four items), avoidance (seven items) and arousal (six items) during the previous month (criterion E). Participants specify how frequently they have experienced various difficulties. There are four response options ranging from 'not at all or only one time', which would score 0 to '5 or more times a week / almost always' which would score 3. Total possible 'severity' scores on this instrument range from 0 to 51. In accordance with the DSM IV criteria, PTSD is considered likely if at least one re-experiencing symptom (criterion B), three avoidance symptoms (criterion C) and two arousal symptoms (criterion D) are present. Although this tool was designed for use with assault victims, the authors suggest the wording can be modified 'for different trauma populations' (pp.472). Therefore the version of the questionnaire used for this study refers to the 'birth' rather than 'assault', as used in the original, thus enhancing face validity. Foa et al. (1993) report the PSS-SR has satisfactory internal consistency (Cronbach's alpha = .85), test-retest reliability of .74 and good concurrent validity (all correlations with other measures of pathology > r = .30, significant at p < .05). The PSS-SR has excellent specificity (100%) but low sensitivity (62%); Ayers and Pickering (2001; pp.113) describe this as a 'conservative measure' of PNPTSD, which they consider 'prudent ... given the controversial nature of the disorder'. The PSS-R was developed to diagnose PTSD according to DSM-III-R (APA, 1987), however as Foa et al. (1997; pp447) note, DSM-IV made only 'minor changes' to this criteria. These items are preceded by six items adapted from the Posttraumatic Diagnostic Scale (PDS; Foa et al., 1997) in consultation with one of the debriefing midwives, which were used to ascertain whether the women's most recent experience of birth meets
DSM-IV criterion A for being classified as a traumatic event. Criterion A1 (exposure to a traumatic stressor) is considered met if at least one of the first four items was experienced. Criterion A2 is considered met if at least one of items five and six were experienced. The addition of the six items referred to above enables assessment of DSM-IV criterions A, B, C, D and E for PTSD. Use of the entire PDS which also assesses for criterion F, instead of the PSS-SR, was considered but rejected as the additional 24 items in this measure would have added considerably to the questionnaire completion time.

A further measure was used to obtain a baseline profile of women’s negative appraisals about any trauma they have experienced in childbirth and/or its consequences, and to explore whether midwife debriefing leads to change in this in accordance with the third objective.

There are few measures of trauma related appraisal; the Posttraumatic Cognitions Inventory (PTCI; Foa et al. 1999) is such a measure, which was validated on survivors of various traumatic events including illness, accidents, combat and torture. The PTCI has been used to identify change in trauma related appraisals, in female survivors of sexual and nonsexual assault (Foa & Rauch, 2004) and motor vehicle accident survivors (Maercker et al., 2006). This inventory has 33 items which make up three scales: negative cognitions about the self (21 items), negative cognitions about the world (seven items) and self-blame (five items). Participants are asked to specify how much they agree or disagree with each item; there are seven response options ranging from ‘totally disagree’ (which scores 0) to ‘totally agree’ (which scores 7). A total score is calculated; as the scales each contain a different number of items, mean item responses are calculated to make the scale scores comparable. Foa et al. (1999) report good internal consistency (Cronbachs alpha = 0.97), test-retest reliability of .85 and discriminant validity (p < .001).

The final objective was to explore whether women who attend midwife debriefing are less satisfied with their emotional and practical support than those who do not. The Significant Others Scale (SOS; Power et al. 1988) assesses two emotional and two

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7 The original items were deemed unacceptable and would not have received R&D approval from the hospital due to concerns that the wording may encourage participants to question whether they or their baby had been harmed.
practical social support functions in up to seven individuals, including spouse, mother and father. This questionnaire has been used to assess satisfaction with emotional and practical support in postnatal women (Matthey & Barnett, 1999; Ogrodniczuk, 2004). Participants are asked to indicate, for each relevant individual, how well the individual provides the type of support listed and how things would be if they were exactly as hoped for; discrepancy scores are then calculated. Each item has seven response options, ranging from ‘never’, which scores 1, to ‘always’ which scores 7. Power et al. report test-retest reliability ranging between 0.73 and 0.83 and ‘satisfactory’ criterion validity.

Post questionnaires
The second questionnaire booklet, which was sent to participants approximately one month after the first one was returned, consisted of the Thoughts and Feelings Questionnaire and two open ended questions (appendix VIII) designed to elicit richer data on women’s opinions about whether their thoughts and feelings about their experience of giving birth have changed, and to what they attribute any change.

PROCEDURE
Recruitment
Debriefing group
The recruitment protocol originally granted ethical approval specified that once a debriefing appointment had been made the midwife would forward the woman’s name and contact details to the researcher. The researcher would then post to the woman a questionnaire pack containing a letter inviting them to participate in the study (appendix IX), an information sheet, consent forms (appendix X), questionnaire booklet and pre-paid addressed envelope to return the completed consent forms and questionnaire booklet. However this procedure was unacceptable to the R&D committee of hospital B’s NHS Trust, which preferred that the midwife described the study and obtained verbal permission to post the questionnaire pack to the woman.

All women who made an appointment to attend a debriefing session and met the inclusion criteria were invited to participate in the study.

Comparison group
The recruitment protocol originally granted ethical approval specified that participants for the comparison group would be identified, and their contact details obtained, from
birth records held at the hospitals concerned. However this was unacceptable to the R&D committee of hospital B’s NHS Trust, who preferred that women for the comparison group were approached individually by the researcher while still on the postnatal ward of the hospital after they had had their babies. The researcher would first liaise with the ward manager to ascertain which women met the inclusion criteria and whether any should not be approached for any reason. She would then introduce herself to the women individually, describe the study, give the women a short information sheet (appendix XI) and invite them to participate. If the women agreed verbally to being sent information about participation in the study they were then asked to provide their name, address and telephone number. The researcher would then post to each woman a questionnaire pack containing a letter inviting them to participate in the study, an information sheet, consent forms, questionnaire booklet and pre-paid addressed envelope to return the completed consent forms and questionnaire booklet.

Women for this group were recruited on various days of the week and various times of day to ensure a range of delivery experiences were included. For example recruiting at hospital A only on a Monday morning may have meant women who had elective Caesarean sections were underrepresented; these procedures were only conducted on Mondays to Thursdays, so on a Monday morning women who had an elective Caesarean section the previous Thursday would have returned home and those having one that day may still have been in theatre or recovery.

**Questionnaire Distribution**

The ‘pre’ questionnaire pack was sent to the debriefing group women at least a week before their debriefing session; they were asked to complete and return the consent forms and questionnaire before their session if they agreed to participate. Debriefing group women who did not return the ‘pre’ questionnaire were not followed up as the researcher did not have access to their name and contact details until they supplied this on the consent form.

The ‘pre’ questionnaire pack was sent to comparison group women four to six weeks after recruitment; they were asked to complete and return the consent forms and questionnaire within a week of receiving them. Comparison group women who did not return the ‘pre’ questionnaire within three weeks were telephoned by the
researcher up to two times to verify the questionnaire had been received and to remind them to return it.

Women in both groups who did not wish to take part were asked to signify this by returning the forms uncompleted; if they did so they were not contacted again.

All women who completed the ‘pre’ questionnaire were sent a ‘post’ questionnaire, covering letter (appendix XII), and prepaid addressed envelope approximately one month after they returned the first one. Women who did not return the ‘post’ questionnaire within three weeks were telephoned by the researcher up to two times to verify the questionnaire had been received and to remind them to return it.

ANALYSIS
Quantitative
Where the assumptions for parametric tests were met, t-tests or an ANOVA were used.

Where parametric assumptions were not met, Pearson’s chi-square tests and Wilcoxon Signed Ranks Tests were used. Where Pearson’s chi-square tests were used, if these revealed expected cell counts of less than five then categories were combined whenever possible, as expected cell counts of less than five indicate a reduction in statistical power and consequent risk of a Type I error (Field, 2006). If expected cell counts of less than five remained after this procedure it is noted that differences could not be tested statistically; the information is presented in tables and discussed accordingly.

The data were analysed using SPSS 14.0 for Windows (SPSS Inc, 2005)

Qualitative
Responses to the open ended questions were coded using content analysis which Weber (1990) describes as a suitable method to analyse this information. Responses were assessed by the researcher and categorised as to whether the participant stated they felt better, worse, or their feelings were unchanged. A confederate researcher repeated the exercise and suggested the addition of an ‘ambiguous response’ category. This suggestion was incorporated; nine of the 68 items were re-rated. Next, responses were assessed to ascertain to what the
participants attributed any change. Again a confederate researcher repeated the exercise and ratings of six of the 68 responses were subsequently amended.

**Missing data**

Demographic, and pregnancy and childbirth questionnaires: if women did not respond to a question that item of data was treated as missing, means were calculated on the number of responses received.

Thoughts and feelings questionnaire: if less than 10% of items on the EPDS, PSS-SR or PTCI were missing they were substituted with group means, if more than 10% were missing the participant’s score for that measure only was excluded from the analysis. According to Tabachnick and Fidell (2007), substitution with group means is acceptable when the proportion of missing data is small. If women did not respond to items on the SOS that item of data was treated as missing and means were calculated on the number of responses received.
RESULTS

RECRUITMENT
Debriefing group participants were recruited between December 2006 and May 2007. Comparison group participants were recruited over nine visits to the postnatal wards between December 2006 and March 2007. Referrals to hospital B's debriefing service fell substantially in the data collection period; although those to hospital A's service increased, the average number of women seen across the two sites was seven each month rather than the 18 projected. Almost all potential participants for the comparison group agreed to being sent questionnaire packs, but response rates indicated that fewer returned them than anticipated, so more women were invited to participate than the 90 originally planned (Table 2).

Table 2: Recruitment and participation

<table>
<thead>
<tr>
<th></th>
<th>Debriefing Group</th>
<th>Comparison Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible</td>
<td>42</td>
<td>162</td>
<td>n/a</td>
</tr>
<tr>
<td>Not approached</td>
<td>0</td>
<td>27</td>
<td>n/a</td>
</tr>
<tr>
<td>Invited to participate</td>
<td>42</td>
<td>135</td>
<td>177</td>
</tr>
<tr>
<td>Declined</td>
<td>0</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Pre questionnaire sent</td>
<td>42</td>
<td>124</td>
<td>166</td>
</tr>
<tr>
<td>Opted out</td>
<td>1</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>No response</td>
<td>17</td>
<td>54</td>
<td>71</td>
</tr>
<tr>
<td>Pre questionnaire returned</td>
<td>24</td>
<td>64</td>
<td>88</td>
</tr>
<tr>
<td>Transfer from comparison to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>debriefing group</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Excluded (^8)</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sub total</td>
<td>26</td>
<td>61</td>
<td>87</td>
</tr>
<tr>
<td>Post questionnaire sent (^9)</td>
<td>23</td>
<td>61</td>
<td>84</td>
</tr>
<tr>
<td>Post questionnaire returned</td>
<td>18</td>
<td>50</td>
<td>68</td>
</tr>
<tr>
<td>Response rate (^10)</td>
<td>78%</td>
<td>82%</td>
<td>81%</td>
</tr>
</tbody>
</table>

\(^8\) One participant was recruited to the comparison group but then had debriefing before completing the 'pre' questionnaire, so could not be transferred to the debriefing group.

\(^9\) Insufficient time elapsed between receipt of 'pre' questionnaires and data collection cut off for this write-up, for the 'post' questionnaires to be sent to three women in the debriefing group. At the time of writing, data collection continues.

\(^10\) Calculated as the % of the women that returned the 'pre' questionnaire who also returned the 'post' questionnaire.
Reasons women were not approached or declined participation are summarised in Table 3.

Table 3: Reasons women were not approached or declined participation

<table>
<thead>
<tr>
<th>Reason</th>
<th>Not invited</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>As advised by ward staff, no reason given</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Baby not born at the hospital</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Child protection issues</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Not fluent in English</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Asleep</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Absent from ward (mothers of babies on special care baby unit)</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Feeding baby</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>'Unwell'</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>'Tired'</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Other children at home</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Inconvenient</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>11</td>
</tr>
</tbody>
</table>

Debriefing referrals

During the six month recruitment period over 3000 women gave birth and 42 (equivalent to 1.4%) were referred for debriefing and invited to participate in this study. Of the 23 women who returned questionnaires, six were referred by a midwife, six by a health visitor, and three self-referred; the remainder did not respond to this question. Further analysis of referral pathways could not be conducted due to small cell counts. Of the 26 women who had given birth before, one woman in each group had been referred to midwife debriefing following a previous labour.

Summary report

Participants were offered a summary report of the research findings. Of the 84 women who returned their first questionnaires, 74 requested a copy, demonstrating great interest in the outcome of this project from participants.

DEMOGRAPHIC, PREGNANCY AND CHILDBIRTH DATA

This section considers demographic, pregnancy and childbirth data relating to the 23 debriefing group women and 61 comparison group women who returned at least one questionnaire. As two sites were used demographic data were compared between women from each hospital within each group (summary in appendix XIII). As no

Based on an annual rate of over 6000 births between the two hospitals concerned.
significant differences were identified in either group, women from both hospitals have been combined into a single ‘debriefing’ group and a single ‘comparison group’. Regarding pregnancy and childbirth data, no significant differences were identified between women from each hospital within the debriefing group; two significant differences in pain relief usage were identified in the comparison group, which are noted in the relevant section (summary in appendix XIV).

**DEMOGRAPHIC DATA**

An overall summary of the demographic variables is presented in Table 4.

<table>
<thead>
<tr>
<th>Table 4: Demographic information</th>
<th>Debriefing</th>
<th>Comparison</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SE)</td>
<td>(n=23)</td>
<td>(n=61)</td>
<td>(n=84)</td>
</tr>
<tr>
<td>Mean (SE)</td>
<td>33.61 (0.84)</td>
<td>30.36 (0.70)</td>
<td>31.25 (0.58)</td>
</tr>
<tr>
<td>Range</td>
<td>26-41</td>
<td>18-42</td>
<td>18-42</td>
</tr>
<tr>
<td><strong>Cultural background:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>(n=21)</td>
<td>(n=56)</td>
<td>(n=77)</td>
</tr>
<tr>
<td>White British</td>
<td>95%</td>
<td>71%</td>
<td>78%</td>
</tr>
<tr>
<td>White Irish</td>
<td>0%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Any other White</td>
<td>0%</td>
<td>23%</td>
<td>17%</td>
</tr>
<tr>
<td>Mixed White and Asian</td>
<td>5%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>Asian or Asian British - Indian</td>
<td>0%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Marital status:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>(n=23)</td>
<td>(n=61)</td>
<td>(n=84)</td>
</tr>
<tr>
<td>Married</td>
<td>61%</td>
<td>71%</td>
<td>68%</td>
</tr>
<tr>
<td>With partner</td>
<td>35%</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Single</td>
<td>4%</td>
<td>3%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Highest level of education:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GCSE / Intermediate level and below</td>
<td>(n=23)</td>
<td>(n=60)</td>
<td>(n=83)</td>
</tr>
<tr>
<td>'A' level / Advanced level</td>
<td>17%</td>
<td>25%</td>
<td>22%</td>
</tr>
<tr>
<td>Degree or higher</td>
<td>74%</td>
<td>50%</td>
<td>57%</td>
</tr>
<tr>
<td><strong>Occupation:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional / managerial / technical</td>
<td>(n=23)</td>
<td>(n=60)</td>
<td>(n=83)</td>
</tr>
<tr>
<td>Skilled non-manual and manual</td>
<td>44%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td><strong>In paid employment before birth:</strong></td>
<td>(n=23)</td>
<td>(n=61)</td>
<td>(n=84)</td>
</tr>
<tr>
<td>Yes</td>
<td>83%</td>
<td>75%</td>
<td>77%</td>
</tr>
<tr>
<td>No</td>
<td>17%</td>
<td>25%</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Home:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented</td>
<td>(n=23)</td>
<td>(n=61)</td>
<td>(n=84)</td>
</tr>
<tr>
<td>Rented</td>
<td>35%</td>
<td>39%</td>
<td>38%</td>
</tr>
<tr>
<td>Owned</td>
<td>65%</td>
<td>61%</td>
<td>62%</td>
</tr>
</tbody>
</table>

On average, women in the debriefing group were older (M = 33.61, SE = .84) than those in the comparison group (M = 30.36, SE = .70). This difference was significant (t (82) = 2.582, p<.05) but represented only a small sized effect r = .27. The mean

---

12 Field (2005) suggests the reporting of the standard error with t-tests
age at which women gave birth in England and Wales in 2005 was 29.5 years (ONS, 2006, pp.3).

Differences in some categorical variables could not be tested statistically. A larger proportion of women in the debriefing group described their cultural background as ‘White British’, were married and were more highly educated than those in the comparison group. Despite this higher level of education, a smaller proportion of women in the debriefing group had professional / managerial / technical occupations and a larger proportion had occupations in the skilled non-manual and manual category. Debriefing group women with a degree or higher level education tended to hold skilled jobs, whereas similarly educated comparison group women tended to have managerial and technical jobs. A smaller proportion of debriefing group women were married, and a larger proportion living with a partner, than those in the comparison group. No significant differences between group and paid employment ($\chi^2 (1) = .495, p.482$) or type of home ($\chi^2 (1) = .147, p .701$) were identified.

Table 5 illustrates how the women who participated in this research compare to the population of England and Wales on some key demographic variables:

<table>
<thead>
<tr>
<th>Cultural background</th>
<th>Debriefing</th>
<th>Comparison</th>
<th>Total</th>
<th>England &amp; Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>(n=21)</td>
<td>(n=56)</td>
<td>(n=77)</td>
<td>92%</td>
</tr>
<tr>
<td>Mixed</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Asian or Asian British - Indian</td>
<td>5%</td>
<td>0%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Debriefing</th>
<th>Comparison</th>
<th>Total</th>
<th>England &amp; Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>(n=23)</td>
<td>(n=61)</td>
<td>(n=84)</td>
<td>66%</td>
</tr>
<tr>
<td></td>
<td>61%</td>
<td>71%</td>
<td>68%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest level of education</th>
<th>Debriefing</th>
<th>Comparison</th>
<th>Total</th>
<th>England &amp; Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>GCSE / Intermediate level and below</td>
<td>(n=23)</td>
<td>(n=60)</td>
<td>(n=83)</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>17%</td>
<td>25%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>'A' level / Advanced level</td>
<td>9%</td>
<td>25%</td>
<td>21%</td>
<td>25%</td>
</tr>
<tr>
<td>Degree or higher</td>
<td>74%</td>
<td>50%</td>
<td>57%</td>
<td>27%</td>
</tr>
</tbody>
</table>

---

13 Compared to percentage of population as a whole (National Statistics Online)
14 Compared to percentage of women who gave birth in 2005 (ONS, 2006, pp.1)
15 Percentage of people of working age in England 2005 (Department for Education and Skills, 2006)
PREGNANCY AND CHILDBIRTH DATA

Conception

Almost all the babies were conceived naturally (Table 6). Although differences in these categorical variables could not be tested statistically, women in the debriefing group tended to conceive more quickly than those in the comparison group: 73% of debriefing group women conceived within a year compared to 56% of comparison group women. The proportion of unplanned pregnancies was similar in each group.

Table 6: Conception

<table>
<thead>
<tr>
<th></th>
<th>Debriefing</th>
<th>Comparison</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=23)</td>
<td>(n=59)</td>
<td>(n=82)</td>
</tr>
<tr>
<td>Conception method:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural</td>
<td>100%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>Assisted</td>
<td>0%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Time taken to conceive:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=23)</td>
<td>(n=61)</td>
<td>(n=84)</td>
<td></td>
</tr>
<tr>
<td>&lt; 3 months</td>
<td>52%</td>
<td>36%</td>
<td>40%</td>
</tr>
<tr>
<td>3-12 months</td>
<td>21%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>&gt; 12 months</td>
<td>9%</td>
<td>21%</td>
<td>18%</td>
</tr>
<tr>
<td>Unplanned – ‘nice surprise’</td>
<td>9%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>Unplanned – ‘bit of a shock’</td>
<td>9%</td>
<td>13%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Labour and delivery

Data regarding labour and delivery are presented in Table 7, with comparison data where available.
Table 7: Labour and delivery

<table>
<thead>
<tr>
<th></th>
<th>Debriefing (n=21)</th>
<th>Comparison (n=52)</th>
<th>Total (n=77)</th>
<th>England 2006\textsuperscript{16}</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weeks gestation:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 weeks and below</td>
<td>48%</td>
<td>71%</td>
<td>64%</td>
<td></td>
</tr>
<tr>
<td>41 weeks and above</td>
<td>52%</td>
<td>29%</td>
<td>36%</td>
<td></td>
</tr>
<tr>
<td><strong>Labour start:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural</td>
<td>64%</td>
<td>79%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Induced</td>
<td>36%</td>
<td>21%</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Pain relief:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>0%</td>
<td>5%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>TENS</td>
<td>50%</td>
<td>21%</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Birthing pool</td>
<td>10%</td>
<td>0%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Gas and air</td>
<td>80%</td>
<td>67%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Pethidine</td>
<td>20%</td>
<td>26%</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Epidural/spinal block</td>
<td>45%</td>
<td>54%</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>General anaesthetic</td>
<td>20%</td>
<td>0%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td><strong>Delivery:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal</td>
<td>39%</td>
<td>61%</td>
<td>55%</td>
<td>77%</td>
</tr>
<tr>
<td>Elective caesarean</td>
<td>4%</td>
<td>18%</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>Emergency caesarean</td>
<td>57%</td>
<td>21%</td>
<td>31%</td>
<td>14%</td>
</tr>
<tr>
<td>Not assisted</td>
<td>74%</td>
<td>75%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Assisted: forceps</td>
<td>0%</td>
<td>5%</td>
<td>4%</td>
<td>4%</td>
</tr>
<tr>
<td>Assisted: ventouse</td>
<td>26%</td>
<td>13%</td>
<td>16%</td>
<td>7%</td>
</tr>
<tr>
<td>Assisted: forceps &amp; ventouse</td>
<td>0%</td>
<td>7%</td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>

Regarding gestation, 52% of debriefing group pregnancies lasted 41 weeks or longer, compared to 29% of comparison group pregnancies. The difference between the groups was not significant ($x^2 (1) = 3.613, p .057$). There was no significant difference between the groups regarding whether labour started naturally or was induced ($x^2 (1) = 2.002, p <.157$).

On average, women in the debriefing group had higher total analgesia scores ($M = 10.20, SE = .945$), than those in the comparison group ($M = 8.09 SE = .585$). This was not significant ($t (75) = 1.861, p .067$). TENS was used by significantly more women in the debriefing group than the comparison group ($x^2 (1) = 10.468, p <.01$). There was no significant difference between the groups in use of gas and air ($x^2 (1) = 1.256, p .262$) or epidural ($x^2 (1) = .523, p .470$). Differences between the groups on usage of the remaining methods of pain relief could not be tested statistically. It was noted that only comparison group women used no pain relief at all, whereas birthing pools and general anaesthetic were only used by debriefing group women. Within the comparison group, TENS was used by significantly more women from hospital B

\textsuperscript{16} From BirthChoiceUK
than from hospital A ($x^2 (1) = 5.134, p < .05$) and ventouse was used by significantly more women from hospital A than hospital B ($x^2 (1) = 10.124, p < .01$).

Labour duration was divided into two categories: up to and including 18 hours, and over 18 hours. Women in the debriefing group were significantly more likely to report a labour of over 18 hours, ($x^2 (1) = 11.037, p < .01$).

Debriefing group women were significantly more likely to have had an emergency Caesarean section than comparison group women ($x^2 (1) = 9.689, p < .01$). Differences between the groups on whether or not delivery was assisted by forceps, ventouse or both could not be tested statistically.

The results of tests to identify whether the number of people who provided personal and professional support during labour differed between the two conditions did not reveal significant differences. The debriefing group women’s score for professional support ($M = 1.52, SE = .176$) was similar to that of the comparison group ($M = 1.53, SE = .102$), ($t (81) = -.059, p .953$). Likewise the debriefing group women’s score for personal support ($M = 1.26, SE = .129$) was similar to that of the comparison group ($M = 1.25, SE = .097$), ($t (81) = -.059, p .951$).

Debriefing group women were significantly more likely to describe their labour as ‘worse than expected’ than comparison group women ($x^2 (1) = 19.133, p < .001$).

**Babies**

In total 87 babies were born to participants, including three sets of twins born to women in the comparison group. The rate of multiple births, at 0% in the debriefing group and 3.6% in the comparison group, compares to the average for England and Wales in 2005 of 1.5% (ONS, 2006). Debriefing group women were approximately equally likely to have had a boy (12) or a girl (11) (Table 8). Excluding those who had twins, a greater proportion of women in the comparison group had a boy (33 women) than a girl (25 women). This difference between the groups was not significant ($x^2 (1) = .149, p .700$). Furthermore, of the six twins born to three women in the comparison group, five were boys.
Differences in the baby’s age group could not be tested statistically; this information is presented in Table 9.

Table 9: Baby age

<table>
<thead>
<tr>
<th>Age group</th>
<th>Debriefing (n=23)</th>
<th>Comparison (n=61)</th>
<th>Total sample England &amp; Wales</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-8 weeks</td>
<td>22%</td>
<td>87%</td>
<td>69%</td>
</tr>
<tr>
<td>9-12 weeks</td>
<td>26%</td>
<td>11%</td>
<td>16%</td>
</tr>
<tr>
<td>13-16 weeks</td>
<td>13%</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>17-20 weeks</td>
<td>4%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>21-26 weeks</td>
<td>4%</td>
<td>0%</td>
<td>1%</td>
</tr>
<tr>
<td>27-52 weeks</td>
<td>9%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>53-78 weeks</td>
<td>13%</td>
<td>0%</td>
<td>4%</td>
</tr>
<tr>
<td>79-104 weeks</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>&gt;105 weeks</td>
<td>9%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The considerable variation between the two groups in the current age of the baby whose birth was being investigated may be because women in the debriefing group could attend debriefing at any time after the birth, whereas those in the comparison group were sent questionnaires when their babies were around one month old.

The birth weight of babies born in each group was not significantly different \( \chi^2 (1) = .539, p .463 \) (Table 10). Compared to babies born in England and Wales in 2005, in both groups a greater proportion weighed over 3.5kg.

Table 10: Baby birth weight

<table>
<thead>
<tr>
<th>Birth weight(^{18})</th>
<th>Debriefing (n=23)</th>
<th>Comparison (n=61)</th>
<th>Total sample</th>
<th>England &amp; Wales(^{19})</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;3.5kg</td>
<td>43%</td>
<td>52%</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>3.5kg +</td>
<td>57%</td>
<td>48%</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

\(^{17}\) ONS (2006, pp.1)

\(^{18}\) for twins lowest birth weight used

\(^{19}\) ONS (2006, pp.44)
Obstetric History

There was no significant difference between the groups in whether the woman had been pregnant before ($\chi^2 (1) = 1.180, p = .672$).

Differences between the groups regarding the outcome of previous pregnancies could not be tested statistically. It can be seen that 44% of women in the debriefing group had a previous abortion, compared to 11% of women in the comparison group (Table 11). Two women in the debriefing group reported five previous live births each, whereas no women in the comparison group reported more than two previous live births.

Table 11: Obstetric History

<table>
<thead>
<tr>
<th>Women who had previous:</th>
<th>Debriefing (n=23)</th>
<th>Comparison (n=61)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>61%</td>
<td>56%</td>
<td>57%</td>
</tr>
<tr>
<td>Abortion</td>
<td>44%</td>
<td>11%</td>
<td>20%</td>
</tr>
<tr>
<td>Miscarriage</td>
<td>26%</td>
<td>20%</td>
<td>21%</td>
</tr>
<tr>
<td>Still birth</td>
<td>4%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Live birth</td>
<td>22%</td>
<td>34%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Women who had given birth before were asked whether their most recent labour was better, worse or the same as their previous experience. Differences between the groups could not be tested statistically, as few women had given birth before. Whilst 70% of comparison group women who had given birth before rated their most recent labour as better than their previous one, none of those in the debriefing group did (Table 12). Conversely, 80% of debriefing group women who had given birth before rated their most recent labour as worse than previous compared to only 15% of those in the comparison group.

Table 12: Rating of labour compared to previous

<table>
<thead>
<tr>
<th></th>
<th>Debriefing (n=5)</th>
<th>Comparison (n=20)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better</td>
<td>0%</td>
<td>70%</td>
<td>56%</td>
</tr>
<tr>
<td>Same</td>
<td>20%</td>
<td>15%</td>
<td>16%</td>
</tr>
<tr>
<td>Worse</td>
<td>80%</td>
<td>15%</td>
<td>28%</td>
</tr>
</tbody>
</table>
THOUGHTS AND FEELINGS QUESTIONNAIRE

This section considers data relating to ‘pre’ and ‘post’ questionnaires completed by 18 debriefing group women and 50 comparison group women.

SYMPTOMS AND SYMPTOM CHANGE

Levels of PNPTSD and PND were investigated to describe baseline symptoms and identify any improvements following debriefing.

Postnatal PTSD

Significantly more women in the debriefing group met criteria A, B, C and D initially compared to the comparison group: Criterion A ($x^2 (1) = 4.758, p < .05$), Criterion B ($x^2 (1) = 20.510, p < .01$), Criterion C ($x^2 (1) = 14.686, p < .01$) and Criterion D ($x^2 (1) = 8.032, p < .01$). The proportion of participants reaching each criterion is summarised in Table 13.

Table 13: Proportion reaching PTSD diagnostic criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Debriefing</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>No trauma symptoms</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Criterion A1: Exposure – indicative</td>
<td>89%</td>
<td>56%</td>
</tr>
<tr>
<td>Criterion A2: Response – indicative</td>
<td>82%</td>
<td>46%</td>
</tr>
<tr>
<td>Both Criteria A1 and A2 met</td>
<td>71%</td>
<td>40%</td>
</tr>
<tr>
<td>Criterion B: Re-experiencing</td>
<td>100%</td>
<td>38%</td>
</tr>
<tr>
<td>Criterion C: Avoidance</td>
<td>67%</td>
<td>18%</td>
</tr>
<tr>
<td>Criterion D: Arousal</td>
<td>94%</td>
<td>58%</td>
</tr>
<tr>
<td>All of Criteria A1, A2, B, C, D and E20 met</td>
<td>56%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Changes in symptoms of PTSD21

As presented in Table 14, there was no change in the proportion of debriefing group women who met criteria B (100%) and D (94%), whereas those who met criterion C decreased from 67% to 56%. Fewer comparison group women met each criterion at ‘post’ than at ‘pre’. Those who met criterion B dropped from 38% to 32%, those who met criterion C dropped from 18% to 14% and those who met criteria D dropped from 58% to 48%.

20 Criterion E is considered met if at least one other criterion is met, as the questionnaire asks about symptoms present during the previous month.

21 As criterion A relates to exposure and response to the birth as an extreme stressor, this would not be expected to change between ‘pre’ and ‘post’.
Research Dossier: Major research project

Table 14: Change in proportion of each group reaching diagnostic criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Debriefing ‘pre’</th>
<th>Debriefing ‘post’</th>
<th>Comparison ‘pre’</th>
<th>Comparison ‘post’</th>
</tr>
</thead>
<tbody>
<tr>
<td>B: Re-experiencing</td>
<td>100%</td>
<td>100%</td>
<td>38%</td>
<td>32%</td>
</tr>
<tr>
<td>C: Avoidance</td>
<td>67%</td>
<td>56%</td>
<td>18%</td>
<td>14%</td>
</tr>
<tr>
<td>D: Arousal</td>
<td>94%</td>
<td>94%</td>
<td>58%</td>
<td>48%</td>
</tr>
</tbody>
</table>

The median number of symptoms reported for each criterion is detailed in Table 15.

Table 15: Median number of symptoms reported pre and post

<table>
<thead>
<tr>
<th></th>
<th>Debriefing</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-experiencing – pre</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>- post</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Change</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Avoidance – pre</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>- post</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Change</td>
<td>-1</td>
<td>-1</td>
</tr>
<tr>
<td>Arousal – pre</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>- post</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Change</td>
<td>0</td>
<td>-1</td>
</tr>
</tbody>
</table>

PSS severity scores at ‘pre’ and ‘post’ were also calculated; these take into account the symptoms experienced and their frequency. Data for both groups was subjected to square root transformation due to significant positive skew and kurtosis which was identified in the comparison group data. Two outliers were identified and removed. A Levene’s test was not significant, indicating variances were homogeneous.

A mixed between and within subjects ANOVA identified significant main effects for group (debriefing compared to comparison) \( (F(1,64) = 57.657, p <.001) \) and time (‘pre’ scores compared to ‘post’ scores) \( (F(1,64) = 11.520, p = .001) \), indicating significant differences between the different groups and the different time points. However interaction between time and condition was not significant \( (F(1,64) = 1.355, p = .249) \).

There was no significant difference between the two groups regarding the proportion of women who improved, remained unchanged or deteriorated \( (x^2(2) = .357, p = 0.807) \); as can be seen in Table 16 there was considerable change within each group.
Table 16: Changes in PSS severity between pre and post

<table>
<thead>
<tr>
<th></th>
<th>Unchanged</th>
<th>Improved</th>
<th>Mean score decrease</th>
<th>Deteriorated</th>
<th>Mean score increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debriefing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=18)</td>
<td>11%</td>
<td>61%</td>
<td>-9.5</td>
<td>26%</td>
<td>+4.4</td>
</tr>
<tr>
<td>Comparison</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=50)</td>
<td>16%</td>
<td>54%</td>
<td>-3.5</td>
<td>30%</td>
<td>+3.5</td>
</tr>
</tbody>
</table>

Postnatal depression

Two participants did not complete sufficient (>90%) of the EPDS items; their scores were excluded from the analysis.

The data for both groups was subjected to log transformation due to significant positive skew and kurtosis in the comparison group data. Two outliers were identified in the debriefing group 'post' data and removed. A Levene's test then indicated variances were not homogeneous, signifying the data was unsuitable for an ANOVA. Two t-tests have therefore been used with the probability value for statistical significance to be achieved adjusted to 0.025 (Field, 2005). The outliers were reinstated in order to retain valuable data, as with them included the distribution was normal.

On average women in the debriefing group had significantly higher initial EPDS scores (M = 1.0315, SE=.03857) than women in the comparison group (M = 0.7663, SE = 0.04915), \( t(58.628) = 4.244, p<.001, r=.48 \) (equal variances not assumed).

Two EPDS cut-off scores are suggested in order to identify whether depression is 'possible' and 'probable'. Upon entering the study, significantly more women in the debriefing group reached the cut-off for possible depression compared to those in the comparison group \( (\chi^2 (1) = 5.797, p <.05) \). It was not possible to statistically test the difference between the groups in reaching the cut-off for probable depression upon entering the study due to small expected cell counts; however 24% of the debriefing group fell into this category compared to 10% of the comparison group.
Changes in symptoms of PND between ‘pre’ and ‘post’ measures

Changes in EPDS scores are illustrated in Table 17.

Table 17: EPDS scores: pre and post

<table>
<thead>
<tr>
<th></th>
<th>Debriefing (n=17)</th>
<th>Comparison (n=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median EPDS score – pre</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>– post</td>
<td>6</td>
</tr>
<tr>
<td>Change</td>
<td>- 4</td>
<td>-1</td>
</tr>
<tr>
<td>Depression unlikely (score &lt;10) – pre</td>
<td>41%</td>
<td>73%</td>
</tr>
<tr>
<td></td>
<td>– post</td>
<td>76%</td>
</tr>
<tr>
<td>Possible depression (score 10+) – pre</td>
<td>59%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td>– post</td>
<td>24%</td>
</tr>
<tr>
<td>Probable depression (score 13+) – pre</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>– post</td>
<td>24%</td>
</tr>
</tbody>
</table>

EPDS scores in both groups decreased between the ‘pre’ and ‘post’ measures. On average the scores of debriefing group women were not significantly different at ‘post’ (M = 0.7780, SE=.09472), to those of women in the comparison group (M = 0.6402, SE = 0.5635), t (64) = 1.244, p = .218, r= .02 (equal variances assumed).

The proportion of women scoring above the cut-off for possible depression dropped from 59% to 24% in the debriefing group, and from 27% to 14% in the comparison group. The proportion of women scoring above the cut-off for probable depression in the debriefing group did not change and in the comparison group this dropped from 10% to 8%.

A Wilcoxon Signed Ranks Test\textsuperscript{22} indicated EPDS scores in the debriefing group were significantly higher at ‘pre’ (Median = 10) than at post (Median = 6), z = -1.678, p <.05, r = .29. The same was true for the comparison group, EPDS scores were significantly higher at ‘pre’ (Median = 6) than at post (Median = 5), z = -2.657, p <.05, r = .28).

Although these figures refer to the categories of the actual scores obtained, they do not describe the change experienced by the individual women concerned; in order to clarify this the ‘pre’ and ‘post’ scores for each woman were compared. As illustrated in Table 18, 35% of debriefing group women improved compared to 14% of

\textsuperscript{22} Nonparametric test used due to lack of homogeneity of variance, as SPSS does not provide a test statistic for ‘equal variances not assumed’ with a dependant t-test.
comparison group women, however 18% of the debriefing group women deteriorated compared to 4% of the comparison group.

Table 18: EPDS scores: individual changes

<table>
<thead>
<tr>
<th></th>
<th>Debriefing (n=17)</th>
<th>Comparison (n=49)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No change</strong></td>
<td>47%</td>
<td>82%</td>
</tr>
<tr>
<td><strong>Improvement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From probable to possible</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>From probable to unlikely</td>
<td>23%</td>
<td>4%</td>
</tr>
<tr>
<td>From possible to unlikely</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Improvement total</strong></td>
<td>35%</td>
<td>14%</td>
</tr>
<tr>
<td><strong>Deterioration</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From unlikely to possible</td>
<td>0</td>
<td>2%</td>
</tr>
<tr>
<td>From unlikely to probable</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>From possible to probable</td>
<td>18%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Deterioration total</strong></td>
<td>18%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Co-occurrence of PNPTSD and PND

It was not possible to statistically test the difference between the groups in reaching neither, one, or both of full PNPTSD criteria and possible PND upon entering the study due to small expected cell counts. As illustrated in Table 19, 33% of the debriefing group met neither criteria compared to 70% of the comparison group, and 45% of the debriefing group met both criteria compared to 4% of the comparison group.

Table 19: Co-occurrence of PNPTSD and PND

<table>
<thead>
<tr>
<th></th>
<th>Neither met</th>
<th>Full PNPTSD only</th>
<th>Possible PND only</th>
<th>Both Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debriefing (n=18)</td>
<td>33%</td>
<td>11%</td>
<td>11%</td>
<td>45%</td>
</tr>
<tr>
<td>Comparison (n=50)</td>
<td>70%</td>
<td>4%</td>
<td>22%</td>
<td>4%</td>
</tr>
</tbody>
</table>

TRAUMA RELATED APPRAISALS

One participant did not complete sufficient (>90%) PTCI items; their score was excluded from the analysis. Scores on the PTCI were not normally distributed due to a positive skew caused because whilst many comparison group women scored at or around the lowest possible level, many in the debriefing group scored much higher. The data was transformed using log and square root transformation, which still did not produce a normal distribution. Consequently it was not possible to use a parametric test to ascertain whether differences between groups were significant, and so Mann-Whitney tests were used.
When they entered the study debriefing group women scored significantly higher than those in the comparison group on all three scales and PTCI total score, as illustrated in Table 20. All effect sizes were large, apart from that for negative cognitions about the world which was medium.

<table>
<thead>
<tr>
<th></th>
<th>Debriefing median</th>
<th>Comparison median</th>
<th>U</th>
<th>p</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Cog. Self</td>
<td>2.74</td>
<td>1.26</td>
<td>145.50</td>
<td>&lt;.001</td>
<td>-.52</td>
</tr>
<tr>
<td>Negative Cog. World</td>
<td>3.36</td>
<td>1.71</td>
<td>222.50</td>
<td>&lt;.01</td>
<td>-.39</td>
</tr>
<tr>
<td>Self Blame</td>
<td>3.30</td>
<td>1.60</td>
<td>141.50</td>
<td>&lt;.001</td>
<td>-.53</td>
</tr>
<tr>
<td>PTCI Total</td>
<td>103.00</td>
<td>45.00</td>
<td>129.00</td>
<td>&lt;.001</td>
<td>-.54</td>
</tr>
</tbody>
</table>

Changes in trauma related cognitions

Wilcoxon Signed Ranks Tests were used to identify whether changes in scales and total scores in either group were significant. Debriefing group scores were not significantly different between ‘pre’ and ‘post’ measures on negative cognitions about self (z = -1.786, p = .074), negative cognitions about the world (z = -1.257, p = .209), self blame (z = -1.787, p = .074), or on PTCI total (z = -1.681, p = 0.093). Similarly comparison group scores were not significantly different between pre and post measures on negative cognitions about the self (z = -1.027, p = .305), negative cognitions about the world (z = -.047, p = .963), self blame (z = -.86, p = .390), or on PTCI total (z = -.782, p = 0.434). Neither group changed significantly in any of these measures, however for each scale score and the total score, that of the debriefing group declined more than that of the comparison group between ‘pre’ and ‘post’. Median, minimum and maximum scores for each scale and total score at ‘pre’ and ‘post’ are presented in Table 21. Whilst the trend for most scores was to decrease between ‘pre’ and ‘post’, the maximum score of women in the comparison group increased between measures for both negative cognitions about the self and PTCI total score.
Table 21: PTCI scale scores

<table>
<thead>
<tr>
<th></th>
<th>Debriefing</th>
<th>Comparison</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>‘pre’</td>
<td>‘post’</td>
</tr>
<tr>
<td>Negative Cognitions</td>
<td>Median</td>
<td>2.7</td>
</tr>
<tr>
<td>about the Self</td>
<td>Minimum</td>
<td>1.2</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
<td>5.1</td>
</tr>
<tr>
<td>Negative Cognitions</td>
<td>Median</td>
<td>3.4</td>
</tr>
<tr>
<td>about the World</td>
<td>Minimum</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
<td>5.9</td>
</tr>
<tr>
<td>Self Blame</td>
<td>Median</td>
<td>3.3</td>
</tr>
<tr>
<td></td>
<td>Minimum</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
<td>7.0</td>
</tr>
<tr>
<td>PTCI total</td>
<td>Median</td>
<td>103.0</td>
</tr>
<tr>
<td></td>
<td>Minimum</td>
<td>46.0</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
<td>175.0</td>
</tr>
</tbody>
</table>

Scores of women in the debriefing group remained significantly higher at ‘post’ than those in the comparison group on all three scales and PTCI total score as illustrated in Table 22, however all effect sizes decreased between pre and post.

Table 22: ‘Post’ PTCI scales and total

<table>
<thead>
<tr>
<th></th>
<th>Debriefing median</th>
<th>Comparison median</th>
<th>U</th>
<th>p</th>
<th>r</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Cog. Self</td>
<td>2.21</td>
<td>1.07</td>
<td>184.00</td>
<td>&lt;.001</td>
<td>-.46</td>
</tr>
<tr>
<td>Negative Cog. World</td>
<td>3.00</td>
<td>1.43</td>
<td>277.50</td>
<td>&lt;.05</td>
<td>-.30</td>
</tr>
<tr>
<td>Self Blame</td>
<td>2.70</td>
<td>1.20</td>
<td>196.50</td>
<td>&lt;.001</td>
<td>-.44</td>
</tr>
<tr>
<td>PTCI Total</td>
<td>86.50</td>
<td>43.00</td>
<td>161.00</td>
<td>&lt;.001</td>
<td>-.49</td>
</tr>
</tbody>
</table>

SOCIAL SUPPORT

Not all participants provided ratings for all possible supportive individuals; responses were therefore aggregated to provide mean scores for each individual. Information obtained from the SOS was analysed by function and by individual.

Social support by function

As illustrated in Table 23, discrepancies between ideal and actual practical and emotional support were higher for debriefing group women than comparison group women, indicating women in the debriefing group were less satisfied with the emotional and practical support they received than comparison group women.
Table 23: Aggregated means for emotional and practical support

<table>
<thead>
<tr>
<th>Function</th>
<th>Group</th>
<th>Actual</th>
<th>Ideal</th>
<th>Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>Debriefing</td>
<td>4.56</td>
<td>6.20</td>
<td>1.64</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>5.37</td>
<td>6.01</td>
<td>0.64</td>
</tr>
<tr>
<td>Practical</td>
<td>Debriefing</td>
<td>4.51</td>
<td>6.01</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>5.24</td>
<td>5.97</td>
<td>0.73</td>
</tr>
</tbody>
</table>

The authors of the SOS reported discrepancies of 0.6-1.2 for emotional support and 0.4 to 1.00 for practical support; the comparison group scored within these ranges for both categories, whilst the debriefing group scored above them.

*Social support by individuals*

As shown in Table 24, the ideal level of support for almost all individuals was similar in both groups; debriefing group women were less satisfied with the support from every individual listed compared to those in the comparison group.

Table 24 – Aggregated means for support by individuals

<table>
<thead>
<tr>
<th>Individual</th>
<th>Group</th>
<th>Actual</th>
<th>Ideal</th>
<th>Discrepancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>Debriefing</td>
<td>5.99</td>
<td>6.71</td>
<td>0.72</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>6.17</td>
<td>6.73</td>
<td>0.57</td>
</tr>
<tr>
<td>Mother</td>
<td>Debriefing</td>
<td>3.90</td>
<td>6.00</td>
<td>2.10</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>5.79</td>
<td>6.33</td>
<td>0.54</td>
</tr>
<tr>
<td>Father</td>
<td>Debriefing</td>
<td>3.70</td>
<td>5.68</td>
<td>1.98</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>4.98</td>
<td>5.98</td>
<td>1.00</td>
</tr>
<tr>
<td>Closest sibling</td>
<td>Debriefing</td>
<td>4.27</td>
<td>5.89</td>
<td>1.63</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>5.14</td>
<td>6.05</td>
<td>0.91</td>
</tr>
<tr>
<td>Other sibling</td>
<td>Debriefing</td>
<td>3.85</td>
<td>5.75</td>
<td>1.90</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>4.36</td>
<td>5.45</td>
<td>1.09</td>
</tr>
<tr>
<td>Child</td>
<td>Debriefing</td>
<td>4.75</td>
<td>6.25</td>
<td>1.50</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>4.90</td>
<td>5.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Friend</td>
<td>Debriefing</td>
<td>5.30</td>
<td>6.44</td>
<td>1.14</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>5.79</td>
<td>6.36</td>
<td>0.56</td>
</tr>
</tbody>
</table>

For debriefing group women the smallest discrepancies were in support from their spouse and friend, and the largest were in support from their mother and father. For comparison group women the smallest discrepancies were with support from their child and mother, and the largest were with support from their other sibling and father. There was no significant difference between the number of individuals rated by women in the debriefing group (M = 4.83, SE .185) and those rated by the comparison group (M = 5.12, SE .123), t (66) = -1.226, p = .225.
Discrepancy scores for both groups were subjected to log transformation due to significant positive skew and kurtosis in the comparison group data. Six outliers were identified in the comparison group data: two for mother, two for child, one for father and one for friend. These cases were retained as the data were input correctly and a Levene’s test indicated variances were homogenous. Independent samples t-tests were conducted to identify whether the differences between the two groups in satisfaction with support received from the individuals listed were significant. As can be seen in Table 25, debriefing group women were significantly more dissatisfied with the social support received from their mother, father, closest sibling, child and friend than comparison group women.

<table>
<thead>
<tr>
<th></th>
<th>Debriefing mean</th>
<th>SE</th>
<th>Comparison mean</th>
<th>SE</th>
<th>df</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse</td>
<td>0.80</td>
<td>.047</td>
<td>0.76</td>
<td>.026</td>
<td>64</td>
<td>.734</td>
<td>ns</td>
</tr>
<tr>
<td>Mother</td>
<td>1.03</td>
<td>.065</td>
<td>0.73</td>
<td>.035</td>
<td>60</td>
<td>4.289</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Father</td>
<td>1.02</td>
<td>.064</td>
<td>0.85</td>
<td>.033</td>
<td>54</td>
<td>2.554</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Closest sibling</td>
<td>0.98</td>
<td>.055</td>
<td>0.84</td>
<td>.029</td>
<td>59</td>
<td>2.318</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Other sibling</td>
<td>1.01</td>
<td>.118</td>
<td>0.85</td>
<td>.055</td>
<td>23</td>
<td>1.278</td>
<td>ns</td>
</tr>
<tr>
<td>Child</td>
<td>0.99</td>
<td>.088</td>
<td>0.63</td>
<td>.060</td>
<td>5</td>
<td>3.304</td>
<td>&lt;.05</td>
</tr>
<tr>
<td>Friend</td>
<td>0.87</td>
<td>.060</td>
<td>0.75</td>
<td>.027</td>
<td>61</td>
<td>2.120</td>
<td>&lt;.05</td>
</tr>
</tbody>
</table>

QUALITATIVE DATA

Open ended questions invited participants to state whether their thoughts and feelings had changed between completing the two questionnaires, and if so how. They were also asked to what they attributed any change. Change responses were coded using content analysis and a summary is provided in Table 26.

<table>
<thead>
<tr>
<th></th>
<th>No change</th>
<th>Yes, better</th>
<th>Yes, worse</th>
<th>Ambiguous</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Debriefing (n=18)</td>
<td>6%</td>
<td>61%</td>
<td>11%</td>
<td>22%</td>
<td>0%</td>
</tr>
<tr>
<td>Comparison (n=50)</td>
<td>50%</td>
<td>26%</td>
<td>2%</td>
<td>10%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Responses were also assessed to ascertain to what the participants attributed any change. All but one of the debriefing group women who said their feelings had changed for the better attributed this change to the debriefing, as did one who said her feelings had got worse, and three whose responses were ambiguous. Four women in the debriefing group mentioned ‘time’; other responses included ‘antidepressants’, and ‘discussing the experience with partner and friends’.
Three comparison group women who reported their feelings had changed for the better attributed this to 'time', as did one woman whose response was ambiguous. Three women in this group who reported their feelings had changed for the better attributed this to improvements in their baby's physical well-being, and two to improvements in their own physical well-being. 'Adjusting to motherhood' and 'feeling more confident with the baby' were also mentioned.
DISCUSSION

This section begins with an outline and discussion of the profile obtained of women who attended midwife debriefing. It goes on to consider whether each hypothesis has been upheld by the study, discuss the findings and some limitations of the study, and suggest recommendations for clinical practice and further research.

PROFILE

Debriefing group women were significantly older than comparison group women, and more likely to describe their cultural background as White British, be living with a partner rather than married, be more highly educated and have skilled jobs. On average debriefing group women conceived more quickly, had longer pregnancies and significantly longer labours than comparison group women. They were significantly more likely to use TENS, have an emergency caesarean, and rate their labour as worse than expected. On average debriefing group babies were older when their mothers entered the study than comparison group babies; a greater proportion of babies in the comparison group were male, and from multiple births. Debriefing group women were more likely to have had an abortion, and those who had given birth before were more likely to rate their most recent birth as worse than their previous experience.

Upon entering the study, all debriefing group women reported some symptoms of PNPTSD; they were significantly more likely to do so than comparison group women. Debriefing group women were also significantly more likely to meet all of DSM-IV criteria A, B, C, D and E for PTSD, reach the cut-off for possible depression and experience negative trauma related appraisals regarding labour and childbirth than comparison group women.

This profile of women who attend midwife debriefing services creates an important knowledge base of information regarding variables pertinent to this group.

The cultural background reported by women in the study was similar to national figures, although none stated their background as black or black British. Seven participants did not specify their cultural background. If national proportions were reflected in a sample of this size, two women would be expected to describe
themselves as black or black British. Compared to national statistics fewer debriefing group women and more comparison group women were married rather than living with their partner. Women who participated in the study were more highly educated than the national average; 74% of debriefing group women and 50% of comparison group women being educated to degree level compared to 27% of the working age population.

Compared to national statistics fewer women in both groups had a vaginal delivery and more had an emergency Caesarean section; the proportion of debriefing group women that had an emergency Caesarean was over four times the national figure. Debriefing group women were significantly more likely to have a longer labour and to have an emergency Caesarean than comparison group women. These factors both appear pertinent to the explanation offered by Schreiber and Galai-Gat (1993: pp.107) of childbirth as a traumatic stressor, as they may involve ‘severe uncontrolled pain, a prolonged state of acute anxiety, uncertainty about the immediate future, loss of control’.

Debriefing group women were significantly more likely to have used TENS; however Carroll et al. (1997) found no evidence of TENS being an effective method of pain relief during labour. Possibly some women used TENS expecting pain relief which did not occur, which may in turn have led to the experiences of pain, anxiety, uncertainty and loss of control suggested by Schreiber and Galai-Gat as being implicated in the formation of PNPTSD. This finding is important as only 54% of hospitals which offer debriefing notify all women of the service (Ayres, et al. 2006) and whilst women who have a delivery which is objectively considered traumatic are often offered debriefing those whose delivery was apparently normal may not be (Axe, 2000). The failure of TENS to provide the expected pain relief may not be perceived as a traumatic stressor by maternity staff and so debriefing may not be offered to women who could then go on to develop PNPTSD.

A greater proportion of debriefing group women had had an abortion than those in the comparison group. Rue et al. (2004) found 65% of American women experienced symptoms of PTSD, and 14.3% met full diagnostic criteria, following abortion; it is possible that for some women abortion constituted a traumatic event and labour was then experienced as re-traumatisation. Further research in this area may help to
clarify this possibility, which could in turn help the development of services for women having a baby following an abortion.

HYPOTHESES

Hypothesis 1a: upheld
Compared to women who do not attend debriefing, those who do will be significantly more likely to experience symptoms of PNPTSD.

Initial scores indicated that significantly more debriefing group women met all of DSM IV PTSD criteria A, B, C, D and E than comparison group women. The proportion of women in both groups who met full DSM-IV criteria, at 56% of the debriefing group and 8% of the comparison group was also higher than the 1.5% to 6% reported by Beck (2004). However as the current study did not assess for criteria F (significant distress or impairment in functioning) these figures are not directly comparable. The proportion of women in both groups who reported some symptoms of PNPTSD, at 100% of the debriefing group and 70% of the comparison group, exceeded the 30% found by Beck (2004). The majority of women apparently experienced some symptoms of PNPTSD, adding support to the suggestion by Mezey and Robbins (2001) that these 'symptoms' should be considered as normal responses to the event of childbirth, rather than pathological.

Debriefing group women also had significantly higher PNPTSD severity scores than comparison group women.

Hypothesis 1b: rejected
Compared to women who do not attend debriefing, those who do will experience a significantly greater improvement in symptoms of PNPTSD.

On average PNPTSD severity scores for both groups decreased significantly between 'pre' and 'post', they remained significantly higher in the debriefing group compared to the comparison group at 'post'. One reason for the decrease in scores may be that women in both groups had begun a spontaneous recovery as their symptoms were actually those of a traumatic stress response (Ayers, 2000), indicating that a diagnosis of PNPTSD would be inappropriate. Such an explanation would be consistent with the qualitative responses from four debriefing group women
and three comparison group women who attributed positive changes in their thoughts and feelings to ‘time’. Although most women in both groups reported improvement in symptoms of PNPTSD, 28% of the debriefing group and 30% of the comparison group reported deterioration. The reason for the deterioration in almost a third of scores is unclear. It is of concern that women who had experienced a traumatic birth and hence previously avoided ‘stimuli associated with the trauma’ (DSM-IV) may have been unable to continue such avoidance after answering the first questionnaire, which may then have resulted in re-traumatisation and an increase in other symptoms. A potential negative impact of answering the questionnaires had been recognised in the information sheet provided to participants, which included details of help-lines and suggested other sources of support women could access if they became distressed.

**Hypothesis 2a: upheld**

**Compared to women who do not attend debriefing, those who do will be significantly more likely to experience symptoms of PND.**

On average initial PND scores were significantly higher in the debriefing group than the comparison group. The proportion of women with possible depression in both groups was higher than the 24% suggested by Small et al. (2000), at 59% in the debriefing group, and 27% in the comparison group. It is noted that the 24% suggested by Small et al. (2000) is itself higher than that found in other studies, for example Cox et al. (1993) reported 8%.

**Hypothesis 2b: rejected**

**Compared to women who do not attend debriefing, those who do will not experience a significantly greater improvement in symptoms of PND.**

Median scores in both groups decreased between measures and fewer women in each group reached the cut-off for possible depression at ‘post’. Although 35% of women in the debriefing group reported improvement in symptoms of depression at ‘post’ compared to ‘pre’, 18% reported deterioration. There was less change in the comparison group, with 14% reporting improvement and 4% deterioration.

The finding of an improvement in depression symptoms in comparison group women was in accord with Shakespeare et al. (2003), who note PND symptoms peak four to
six weeks after giving birth. 'Pre' questionnaires were sent to women in this group when their babies were four to six weeks old and most were completed at around this time; 'post' questionnaires were sent about six weeks later, by which time some symptoms might be expected to have subsided.

Another reason for the decrease in scores may be that women in both groups had begun a spontaneous recovery as their symptoms were actually those of a grief reaction associated with loss as suggested by Nicolson (1990, as cited by Podkolinski, 1998), indicating that a diagnosis of PND would be inappropriate. This finding is again consistent with the comments of three women in this group who attributed a positive change in their thoughts and feelings to 'time'.

The finding of a significant improvement in depression symptoms in women who had debriefing appears to contradict the conclusions of studies conducted by Small et al. (2000) and Priest et al. (2003). However these studies considered debriefing which took place while the women were still in hospital following the birth of their baby, whereas in the current study debriefing occurred at least five weeks afterwards. This finding is important as it indicates the potential impact of the timing of the intervention. As Axe (2000) suggested, after giving birth a woman's immediate attention is likely to be on caring for her new baby and developing new skills rather than on her own wellbeing, thus she may be unable to benefit from debriefing too soon after the birth as it would require her to focus on herself rather than her baby.

**Hypothesis 3: neither upheld or rejected**

Compared to women who do not attend debriefing, those who do will be significantly more likely to experience symptoms of PND and PNPTSD.

It was not possible to statistically test hypothesis 3 due to small expected cell counts; 45% of debriefing group women and 4% of comparison group women met both criteria.

**Hypothesis 4a: upheld**

Compared to women who do not attend debriefing, those who do will be significantly more likely to experience negative trauma related appraisals regarding labour and childbirth.
Debriefing group women scored significantly higher than comparison group women on all three PTCI trauma related appraisal scales and the total score at 'pre' and at 'post', which would appear to lend support to Ehlers and Clarke's (2000) model of PTSD.

**Hypothesis 4b: rejected**

Compared to women who do not attend debriefing, those who do will experience a significantly greater reduction in negative trauma related appraisals regarding labour and childbirth.

Scale and total scores did not change significantly between measures in either group, although they did all decline more in the debriefing group than the comparison group. This finding is insufficient to support Ehlers and Clark (2000), who suggested that education about hospital procedures will modify associated negative trauma related appraisals. The lack of the expected significant reduction in trauma related appraisals in the debriefing group might be because in order to improve cognitive appraisals ‘most maternity professionals’ would require ‘considerable specialist training’ (Gamble & Creedy, 2004; pp.213). Despite the trend for most scores in both groups to decrease between ‘pre’ and ‘post’, the maximum score obtained from women in the comparison group increased for both negative cognitions about the self and PTCI total score. It is postulated again that completing the ‘pre’ questionnaire may have re-traumatised some women thus having a detrimental effect on trauma related appraisals.

**Hypothesis 5: upheld**

Compared to women who do not attend debriefing, those who do will be significantly less satisfied with the emotional and practical support they receive.

There were negative discrepancies in both groups for all individuals listed in actual and ideal social support received. Mean discrepancies in the comparison group were within the ranges quoted by the authors, whilst in the debriefing group they were higher. The ideal level of support for almost all individuals was similar in both groups. As expected, debriefing group women were less satisfied with the support they received than those in the comparison group. These differences were found for all individuals listed and were significant in respect of support received from their
mother, father, closest sibling, child and friend. This finding is consistent with Brugha et al. (1998), Brewin et al. (2000), and Robertson (2004) who argue lack of social support is a risk factor in the development of both PTSD and depression. However, importantly it also highlights a difficulty with the recommendation made in the NICE Guidelines for Antenatal and Postnatal Mental Health (2007a, pp.161), that ‘women who have experienced a traumatic birth are encouraged to make use of natural support systems available from family and friends’. It would seem that women wish to make use of these support systems, but they may simply be unavailable or insufficient for some women.

It is possible the difference between the two groups in satisfaction with social support may be related to the differences in the age of the babies in the two groups. It is postulated that mothers of new babies are perceived as needing more support by individuals in their social networks, which may then taper off as babies grow older although the women concerned may still want a higher level of support.

Overall comments
The initial level of postnatal distress amongst participants in both groups was higher than expected from previous literature. However, Shakespeare et al. (2003, pp.618) found that some women gave ‘deliberately unreliable responses’ on the EPDS when asked to complete it by their health visitor, due to anxiety about possible adverse consequences of answering honestly. It may be that the anonymity provided in the current study enabled women to admit to postnatal distress which might not otherwise have been revealed. It is possible that women invited to participate in the study were more likely to do so if they were experiencing postnatal distress, than women who were not. It is also possible that such distress is a realistic or normal response to childbirth as suggested by Littlewood and McHugh (1997), Mezey and Robbins (2001) and Podkolinski (1998).

The questionnaires used do not provide diagnoses of PNPTSD or PND, which would also have required a clinical interview, but they do provide an indication of symptoms indicative of such diagnoses. As a non-standardised questionnaire was used to assess DSM-IV PTSD criterion A it can only be stated whether it is likely this criterion was met. Also as already noted the PSS-SR does not measure DSM-IV PTSD criterion F. However for many women these areas of functioning may have been
impaired by the arrival of a new baby; it may have been difficult to differentiate the impact of the new baby from that of any PNPTSD symptoms.

It was noted that 33% of the debriefing group women did not meet full criteria for PNPTSD or appear to have PND, highlighting that women with sub-clinical levels of PNPTSD and/or PND may nonetheless wish to utilise debriefing services. In contrast 30% of comparison group women met full criteria for PNPTSD and/or appeared to have PND; 8% met full PTSD criteria, half of whom did not appear to have PND. Screening for PND alone would not have picked up the distress experienced by these women. This finding highlights the importance of the detection of trauma symptoms, and appears to accord with Epperson (1999), who comments that women may not recognise that their experience is atypical; women may have PNPTSD and/or PND without being aware this is the case, and so not seek help. It is also possible that these women were aware of their difficulties but were either unaware of the debriefing service or chose not to use it, perhaps because of the potential stigma of being labelled mentally ill or concern they would be deemed unfit to look after their baby as suggested by Shakespeare et al. (2003). If this is the case it would indicate that not all women find the current provision of services for those experiencing postnatal distress acceptable or accessible. The way postnatal distress is conceptualised by such services may lead to concerns about stigmatisation and negative consequences for some women who therefore do not seek help with their distress. The conceptualisation of postnatal distress was as a psychological symptom rather than a psychiatric condition as suggested by Lyons (1998) might lessen such concerns.

It appears that midwife debriefing accessed when they are ready for it has a beneficial effect on the psychological wellbeing of many women after birth, but this effect is only significant in respect of symptoms of PND. It is unclear why although most women experience improvement in symptoms of PNPTSD and PND, some experience deterioration, and it is not known why some women attributed a change for the worse in their feelings to the debriefing. Rose et al. (2002) suggest that discussing a trauma may interfere with adaptive defence mechanisms and consequently not be experienced as therapeutic by some. Rose et al. (2002) also express concern that the provision of debriefing services may ‘medicalise’ normal distress, and lead to increased awareness and expectations of distress which might not have otherwise occurred. The conceptualisation of some aspects of postnatal
distress as PNPTSD and consequent focus of services on addressing trauma symptoms would therefore appear to be unhelpful, or even detrimental, or some women. Furthermore, Gamble et al. (2002, pp.77) warn that a single debriefing session might 'diminish the importance of this traumatic experience'; they also comment that a single session does not provide ongoing support. This diminishing of the experience and lack of ongoing support may also explain the increase in depression scores in some debriefing group women mentioned earlier. If this is so for women in the current study, then the facility one debriefing service has to refer women on for counselling or to a PND group is vital.

Compared to comparison group women those in the debriefing group were significantly more likely to experience trauma related appraisals and PNPTSD symptoms but did not experience a significantly greater reduction in either, which appears to support Ehlers and Clark's (2000) suggestion that PTSD symptoms are maintained by excessively negative appraisals. However, as the PTCI was designed for use with trauma populations it may have been unsuitable to use with the comparison group. Two comparison group women contacted the researcher, expressing confusion about how to complete this questionnaire; both said it seemed irrelevant to their experience. Possibly other women in this group were similarly confused and decided not to participate.

The SOS provides a useful measure of satisfaction with emotional and practical social support, however it does not provide information about the total number of people involved in the participants’ social networks, and the version used did not allow for more than one friend to be rated. In retrospect it might have been better to replace the items regarding support from a child (to which only seven women responded) with an ‘other’ category.

STUDY LIMITATIONS

Pregnancy and childbirth information
A potential weakness of the study is its reliance on the memory of participants to answer questions regarding their experience of childbirth and labour, about which no independent verifying information was obtained. If hospital records had been used to confirm the information received this may have enhanced the accuracy of this aspect of the study.
Recruitment and response rate
The recruitment rate for both groups was lower than expected. Delays in the granting of R&D approval meant the start of data collection was also delayed and the data collection period was substantially reduced from that originally envisaged. Participation rates in both groups were lower than anticipated; Creedy et al. (2000, pp.105) describe a similar study which also used self-report questionnaires mailed to women; they postulate 'particularly traumatised' women from both groups may have avoided answering. Traumatised women may therefore have been underrepresented in both groups.

Debriefing group
The drop in referrals to one of the debriefing services meant far fewer women were recruited to the debriefing group than had been expected, which in turn had an impact on the uneven group sizes. Amendments to the original recruitment protocol specified by hospital B's R&D committee meant debriefing midwives described the study to women at the time of making the appointment for debriefing. This procedure was not standardised so may have been conducted differently by each midwife, and may also have varied with different women. The power differential between the woman making an appointment and the midwife, and acquiescence, were also potential factors in the recruitment of this group. It may have been hard for women to decline the invitation to participate when asking for the service, especially as the invitation came from the midwife who would provide the debriefing.

Comparison group
The recruitment rate for the comparison group was less than anticipated from similar studies. The response rate for this group, at 82% of women who agreed to participate, was similar to the 86% of women who received standard care obtained by Small et al. (2000). However in Small et al.'s study 79% of the women approached agreed to participate compared to just 47% in the current study. Women were initially approached on the postnatal ward within hours of giving birth, by someone who they perhaps perceived as 'official' but not involved in their care, and invited to participate in the research. Women may have been tired, feeling vulnerable, and preoccupied with their new baby, however the power differential inherent in the situation perhaps meant they acquiesced and agreed to being sent information about the study without fully considering what was being asked of them.
By the time they received the first questionnaire they may have forgotten about the study or not associated it with the conversation they had with the researcher.

Not all women on the postnatal wards were invited to participate, and some who were declined. Three potential participants were excluded because their proficiency in English was inadequate. The study only used participants who did not require an interpreter; therefore conclusions generated are not representative of all women who give birth in the geographical area covered by this study.

Three potential participants declined the invitation, saying they would not have time to complete questionnaires due to having other children at home to care for; this may also have been an issue for some non-responders. Yonkers et al. (2001) found having other infants at home increased the likelihood of depressive symptoms postnatally. This highlights the possibility that women with other children may be underrepresented and rates of depression underestimated in this study.

Other
This study did not control for pre-existing mental health problems or for any other treatments, for example counselling, that women received since giving birth. Mental health problems are common in pregnant women; Yonkers et al. (2001) found around half of the women with PND in their sample had symptoms of major depression before delivery. Two comparison group women mentioned they had attended counselling since giving birth and found this helpful; it is not known whether this involved discussion of their childbirth experience. Therefore it cannot be stated that women in the debriefing group were the only ones in the study to have discussed their birth experience with a healthcare professional. However they were the only ones to have had such a discussion with a midwife who had their medical records and could provide information about the actual event and procedures at the hospital concerned.

As the exact content of debriefing sessions was varied by both midwives according to the needs of the women concerned the women did not have an identical experience, although they should all have had the opportunity to ask questions about the event and clarify aspects of the care they received. Any effect of which midwife undertook the debriefing was not assessed in the current study due to the comparatively small number of women who received this intervention.
It would have been useful to consider the impact of self-referral to debriefing in the analysis but this was not possible as it only applied to three women.

As all the women in this study gave birth in hospitals the research does not represent the experience of women who had home births.

RECOMMENDATIONS FOR CLINICAL PRACTICE
A significantly greater improvement in depression symptoms was found in women who had debriefing when they were ready compared to those in women who did not have debriefing. It is therefore recommended that women are encouraged to attend debriefing in the months following the birth of their baby, at a time when they are more able to focus on their own needs.

As 8% of women in the comparison group appeared to meet PNPTSD criteria A to E it is recommended that routine trauma screening be conducted to detect cases. Although debriefing may not have had a significant impact on PNPTSD it did appear to help with symptoms of PND. However given the high level of pathology that remained after women received debriefing, it is recommended that all such services develop routes to refer women on to specialist trauma services for trauma-focussed CBT or EMDR as recommended by the NICE Guidelines for PTSD (NICE, 2005), or to counselling or PND groups as necessary after they have received debriefing.

Midwives should be alerted that women who use TENS may not experience the pain relief they expect, which may leave them vulnerable to the development of symptoms of PNPTSD. Also, if women are made aware by midwives that TENS may not provide the anticipated pain relief, they may be less likely to experience the uncontrolled pain, anxiety, and uncertainty which Schreiber and Galai-Gat (1993) suggest is implicated in the formation of PTSD.

RECOMMENDATIONS FOR FURTHER RESEARCH
As 8% of comparison group women appeared to meet criteria for PNPTSD further research might clarify why such women do not attend midwife debriefing and identify how services might be improved to make them more accessible.
The median age of babies in the debriefing group was 14 weeks, compared to 7 weeks in the comparison group. Therefore it seems likely any symptoms of PNPTSD and/or PND had lasted longer, were more entrenched and less likely to remit spontaneously in the debriefing group than the comparison group. Thus the true benefit of debriefing may have been underestimated in this study. Research with babies age-matched between the two groups might provide a more accurate measure of comparative change.

Further research into the content of debriefing sessions, perhaps by recording, transcribing and analysing them, might lead to clarification about the precise nature of the intervention. Following this up with semi-structured interviews with the women concerned might identify which aspects of this the women found helpful and help clarify the effectiveness of the intervention.

Previous research considered the outcome of debriefing provided within days of the woman giving birth (Priest et al., 2003; Small et al., 2000) whereas the current study investigated the outcome of debriefing accessed by women when they were ready to attend. The time elapsed since these women gave birth ranged from six weeks to six years, 22% of these women attended debriefing when their baby was more than one year old. Further research might clarify whether there is an optimum time after childbirth for such an intervention to take place.

Debriefing was provided by one service at a Surestart community setting whereas the other service was located within the hospital at which the women attending gave birth. It is possible that some women would be reluctant to return to the hospital at which they gave birth, or experienced returning as re-traumatising. Further research might clarify whether the location of such a service has an impact on attendance or the outcome of the debriefing.

Further research might investigate the attitudes to debriefing of midwives, health visitors and other healthcare professionals who refer women to such a service, and of the midwives who provide it, in order to clarify what impact this might have on who is referred and what service they receive.

As almost a third of women in both groups reported deterioration in PNPTSD symptoms, research into the possibility that the completion of trauma questionnaires
might be re-traumatising in some instances is recommended, to aid understanding of this possibility.

As women in the debriefing group were significantly more likely to have used TENS during labour than those in the comparison group, further research might clarify whether the failure of TENS to provide the expected pain relief might be perceived as a traumatic stressor.

Finally, this study investigated social support obtained from pre-existing social networks; however it is possible that for some women social networks change when they become mothers, leading to new sources of social support. Research investigating changes in social support networks might clarify the comparative importance and respective roles of pre-existing and new social networks at this time.

CONCLUSION
The study found that those who attended midwife debriefing experienced a reduction in distress related to symptoms of PND and PNPTSD; the reduction in PNPTSD symptoms was similar to, and that in PND symptoms significantly greater than, that experienced by comparison group women. Important implications for clinical practice have been identified, and suggestions for further research proposed.
REFERENCES


Care Of Recently Delivered Women And Their Babies. London: National Collaborating Centre for Primary Care and Royal College of General Practitioners.


Ogrodniczuk, J.S. (2004). Increasing a partner's understanding of motherhood significantly reduces postnatal distress and depression in first time mothers with low self esteem. *Evidence Based Mental Health*, 7, 117


Royal College of Obstetricians and Gynaecologists


APPENDIX I
ETHICAL APPROVAL FROM
THE RESEARCH ETHICS COMMITTEE
Ms Claire Pond  
Trainee Clinical Psychologist  
Department of Psychology, University of Surrey  
Guildford  
Surrey GU2 7XH

2 October 2006

Dear Ms Pond

Full title of study: A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth

REC reference number: 06/Q1801/64

Thank you for your letter of 19 September 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:
You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**06/Q1801/64** Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project
Yours sincerely

Chair

Email:

Enclosures: Standard approval conditions

Copy to: University of Surrey, Guildford, Surrey, GU2 7XK
Ms Claire Pond
Trainee Clinical Psychologist
University of Surrey
Guildford
Surrey GU2 7XH

10 November 2006

Dear Ms Pond

Study title: A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth

REC reference: 06/Q1801/64

Amendment number: 1
Amendment date: 01 November 2006

The above amendment was reviewed at the meeting of the Sub-Committee of the REC held on 10 November 2006.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Research governance approval

*All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.*

Statement of compliance

*The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.*

06/Q1801/64: Please quote this number on all correspondence

Yours sincerely

Co-ordinator
Research Ethics Committee
Direct Line:
E-mail:
Copy to: University of Surrey, Guildford, Surrey, GU2 7XK

Enclosures List of names and professions of members who were present at the meeting and those who submitted written comments
Ms Claire Pond  
Trainee Clinical Psychologist  
Guildford  
Surrey GU2 7XH  

22 November 2006  

Dear Ms Pond  

Study title: A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth  

REC reference: 06/Q1801/64  

Amendment number: 2  
Amendment date: 14 November 2006  

The above amendment was reviewed at the meeting of the Sub-Committee of the REC held on 24 November 2006.  

Ethical opinion  

The members of the Committee present decided that it could not give a favourable ethical opinion of the amendment, for the following reasons:  

- The Sub-Committee had concerns regarding data protection. Therefore, please provide written confirmation that the information will not be used for any other purpose and the data will be safely disposed of at the end of the study.  

I regret to inform you that the amendment is therefore not approved. The study should continue in accordance with the documentation previously approved by the Committee.  

Modifying the amendment  

You may modify or adapt the amendment, taking into account the Committee’s concerns. Modified amendments should be submitted on the standard notice of amendment form. The form should indicate that it is a modification of the above amendment.  

A revised notice of amendment must be submitted at least 14 days before you plan to implement the amendment. The Committee will then have 14...
days from the date of receiving the notice in which to notify you that the amendment is rejected, otherwise the amendment may be implemented.

Documents reviewed

The documents reviewed at the meeting were:

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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1801/64: Please quote this number on all correspondence

Yours sincerely

Co-ordinator
Research Ethics Committee
Direct Line:
E-mail:
Copy to: University of Surrey, Guildford, Surrey, GU2 7XK

Enclosures List of names and professions of members who were present at the meeting and those who submitted written comments
Ms Claire Pond  
Trainee Clinical Psychologist  
Guildford  
Surrey  
GU2 7XH  
4 January 2007  

Dear Ms Pond  

Study title: A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth  
REC reference: 06/Q1801/64  

Amendment number: 3  
Amendment date: 18 December 2006  

The above amendment was reviewed at the meeting of the Sub-Committee of the REC held on 05 January 2007.  

Ethical opinion  

The members of the Committee present gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.  

Approved documents  

The documents reviewed and approved at the meeting were:  

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Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Research governance approval

All investigators and research collaborators in the NHS should notify the R&D Department for the relevant NHS care organisation of this amendment and check whether it affects research governance approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1801/64: Please quote this number on all correspondence

Yours sincerely

Co-ordinator
Research Ethics Committee
Direct Line:
E-mail:

Copy to:
University of Surrey
Guildford
Surrey GU2 7XK

Enclosures  List of names and professions of members who were present at the meeting and those who submitted written comments
APPENDIX II
ETHICAL APPROVAL FROM
UNIVERSITY OF SURREY SCHOOL OF HUMAN SCIENCES
ETHICS COMMITTEE
Claire Pond  
Department of Psychology – PsychD  
University of Surrey  

28 November 2006  

Dear Claire  

Reference: 91-PSY-06  
A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth  

Thank you for your submission of the above proposal.  

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.  

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the School Ethics Committee.  

Yours sincerely
APPENDIX III

RESEARCH AND DEVELOPMENT APPROVAL
Midwife Debriefing for Post Natal Psychological Wellbeing

Thank you for receipt of your completed NHS Research and Development Form for the above named study.

I can confirm that the Trust's Research & Development Management Office have approved the study, subject to the appropriate ethical approval being in place.

Your study has been allocated the following reference: 06/162/PON. Please quote this in all future correspondence.

It would be appreciated if you could inform me when the study is complete.

Yours sincerely

Research & Development Manager
HOSPITAL B
Dear Ms Pond,

Re: 06/Q1801/64 A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth.

Thank you for submitting details of your research proposal which I am happy to approve on behalf of O’ NHS Trust.

Trust approval is granted on the basis described in the NHS Ethics application and subsequent substantial amendments, R & D application form, research study protocol and supporting documentation, as well as correspondence with the Trust R & D Office which detailed arrangements for conducting the research at this Trust. Research approval is subject to:

- Completion of research agreement/honorary contract arrangements for yourself prior to any contact with our patients.

Research Governance is designed to promote a positive culture of quality, respect and learning. In order that your project contributes to the knowledge base within the NHS you are strongly encouraged to:

- Disseminate your findings through publication and dissemination.
- Take appropriate measures to protect any intellectual property which may arise
- Collaborate with the R&D Office on providing information on the progress of the project.

Important documents

Please ensure that all study documentation is held safely in a study site file. The attached document "SaSH documentation required for a study site file" details what should be held on file. As the principle investigator, you are responsible for establishing the site file before the start of the project, and for maintaining it during the lifetime of the project. The study site file should be held in a secure location and should be readily available for review at monitoring or audit visits. If you require any further clarification please contact the R & D office.

Required standards

The research supported by the Trust must fall within a framework of Research Governance to ensure the research is of a high quality and that the risks, in particular to participants, are effectively identified and managed. As the principle investigator you should ensure that your study is conducted in accordance with research governance standards and where appropriate ICH/GCP standards. A number of support mechanisms are available to assist researchers meet the
standards of quality and safety. For further information regarding ICH/GCP training, Health and Safety, Data Protection, Intellectual Property Policy and Risk Assessment please refer to the Trust Intranet or the Trust Research Manager.

Changes during the study

Changes to the protocol, study documentation and investigators should be reported to the R & D
APPENDIX IV
‘DEBRIEFING’ GROUP
INFORMATION SHEET
A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully, discuss it with others if you wish, and contact me using the contact details at the end of this sheet if anything is unclear or you would like further information.

What is the purpose of the study? - I am trying to find out more about the effect of midwife debriefing on women's psychological wellbeing after birth in order to suggest future directions for the development of services for women who have recently given birth. I am conducting this research as part of a practitioner doctorate in clinical psychology. The study will run from August 2006 until September 2007, during that time you will be asked to participate on two occasions over approximately one month.

Why have you been chosen? - I am approaching all women who have requested midwife debriefing from (name of service) because I am interested in finding out about how debriefing has affected their feelings following the birth of their baby. Approximately 130 women will participate in the study.

Do you have to take part? - It is up to you to decide whether or not to take part. If you decide to take part please sign the enclosed consent form. This information sheet is for you to keep. If you decide to take part you are free to withhold any personal information or to withdraw at any time, without giving a reason. Any decision you make will not affect the care you receive.

What would taking part involve? - Taking part involves completing questionnaires approximately one month apart, which will take 20-30 minutes on each occasion. The first questionnaires are enclosed so you should complete them and return them in the stamped addressed envelope provided along with the signed consent forms within the next 10 days. It is important that you complete these questionnaires before you have your debriefing session with the midwife. Then, in approximately one months time you will be sent another questionnaire to complete with a stamped addressed envelope for you to return it in. If you decide not to take part please return the uncompleted papers in the envelope provided so that I know not to contact you again. If I do not hear from you within two weeks I will contact you by phone to remind you.

Confidentiality - All information collected during the study will be kept strictly confidential in accordance with data protection laws. It will be given a code number and your name and address will be stored separately at the University of Surrey so that you cannot be recognised from it. After the study period the data will be held in secure storage at the University of Sussex and destroyed after ten years. Direct quotes may be used in the writing up of this research, if so they will be anonymous.
What are the possible advantages and disadvantages of taking part? - There are no anticipated disadvantages of taking part in the study. However if you want to stop your participation for any reason, you are free to do so immediately. It is hoped that the study will contribute to a greater understanding of the effects of midwife debriefing on women’s psychological wellbeing after birth and lead to the development of useful and effective services for women who experience psychological difficulties after birth.

What if you become distressed? - This is unlikely, however some women may experience distress when completing questionnaires about their experience of giving birth. If this is the case there are a number of sources of support available to you:

- The following could be contacted:

  (name and phone number of debriefing midwife)

  Organisation: Birth Trauma Association (BTA)
  Website: [www.bta-association.org.uk/go](http://www.bta-association.org.uk/go)
  Contact: support@bta-association.org.uk (e-mail helpline)

  Organisation: Association for Improvements in the Maternity Services (AIMS)
  Website: [www.aims.org.uk](http://www.aims.org.uk)
  Contact: 0870 765 1433 (telephone helpline)

- You could also consider who else would be able to offer you support such as your GP, other health care professionals, family and friends.

What will happen to the results of the study? - The results of part of this study will be included in a research report in September 2007, and an article might be published in a scientific journal. If you would like a summary of the results please indicate this on the consent form. You will not be identified in any part of the report, article or summary.

Who has reviewed the study? - This study has been approved by The University of Surrey, Surrey and the Research Ethics Committee and the Research and Development department of your local NHS Trust.

Contact details for further information - If you have any questions or concerns about this study, please feel free to contact me on the telephone number or email address below:

Claire Pond
Trainee Clinical Psychologist
c/o Department of Psychology
University of Surrey
Guildford GU2 7XH

tel: 01483 669441
e-mail: [cpond@surrey.ac.uk](mailto:cpond@surrey.ac.uk)

If you do decide to participate I would like to thank you very much for your highly valuable contribution to this research.

If you have any complaints about your participation in this research, in the first instance please contact the Chief Investigator, Claire Pond. The normal National Health Service complaints mechanisms should also be available to you. In the unlikely event of you suffering significant and enduring harm as a result of your participation in this research, the University of Surrey (as sponsor of the research) holds no-fault insurance cover which is intended to provide compensation to participants, regardless of liability. The University of Surrey also has public liability insurance, which covers public liability claims.
APPENDIX V
COMPARISON GROUP
INFORMATION SHEET
A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully, discuss it with others if you wish, and contact me using the contact details at the end of this sheet if anything is unclear or you would like further information.

What is the purpose of the study? - I am trying to find out more about the effect of midwife debriefing on women's psychological wellbeing after birth in order to suggest future directions for the development of services for women who have recently given birth. I am conducting this research as part of a practitioner doctorate in clinical psychology. The study will run from August 2006 until September 2007, during that time you will be asked to participate on two occasions over approximately one month.

Why have you been chosen? - I am approaching women who have had a baby at (name of Hospital) and not requested midwife debriefing because I am interested in comparing their feelings with those of women who have had midwife debriefing following the birth of their baby. The participation of women who have not had debriefing is just as important as that of women who have. Approximately 130 women will participate in the study.

Do you have to take part? - It is up to you to decide whether or not to take part. If you decide to take part please sign the enclosed consent form. This information sheet is for you to keep. If you decide to take part you are free to withhold any personal information or to withdraw at any time, without giving a reason. Any decision you make will not affect the care you receive.

What would taking part involve? - Taking part involves completing questionnaires approximately one month apart, which will take 20-30 minutes on each occasion. The first questionnaires are enclosed so you should complete them and return them in the stamped addressed envelope provided along with the signed consent forms within the next 10 days. Then, in approximately one months time you will be sent another questionnaire to complete with a stamped addressed envelope for you to return it in. If you decide not to take part please return the uncompleted papers in the envelope provided so that I know not to contact you again. If I do not hear from you within two weeks I will contact you by phone to remind you.

Confidentiality - All information collected during the study will be kept strictly confidential in accordance with data protection laws. It will be given a code number and your name and address will be stored separately at the University of Surrey so that you cannot be recognised from it. After the study period the data will be held in secure storage at the University of Sussex and destroyed after ten years. Direct quotes may be used in the writing up of this research, if so they will be anonymous.
What are the possible advantages and disadvantages of taking part? - There are no anticipated disadvantages of taking part in the study. However if you want to stop your participation for any reason, you are free to do so immediately. It is hoped that the study will contribute to a greater understanding of the effects of midwife debriefing on women’s psychological wellbeing after birth and lead to the development of useful and effective services for women who experience psychological difficulties after birth.

What if you become distressed? - This is unlikely, however some women may experience distress when completing questionnaires about their experience of giving birth. If this is the case there are a number of sources of support available to you:

- The following could be contacted:
  
  Organisation: Birth Trauma Association (BTA)
  Website: www.birthtraumaassociation.org.uk
  Contact: support@birthtraumaassociation.org.uk (e-mail helpline)

  Organisation: Association for Improvements in the Maternity Services (AIMS)
  Website: www.aims.org.uk
  Contact: 0870 765 1433 (telephone helpline)

  You could also consider who else would be able to offer you support such as your GP, other health care professionals, family and friends.

What will happen to the results of the study? - The results of part of this study will be included in a research report in September 2007, and an article might be published in a scientific journal. If you would like a summary of the results please indicate this on the consent form. You will not be identified in any part of the report, article or summary.

Who has reviewed the study? - This study has been approved by The University of Surrey, Surrey and the Research Ethics Committee and the Research and Development department of your local NHS Trust.

Contact details for further information - If you have any questions or concerns about this study, please feel free to contact me on the telephone number or email address below:

Claire Pond  
Trainee Clinical Psychologist  
c/o Department of Psychology  
University of Surrey  
Guildford GU2 7XH  
tel: 01483 689441  
e-mail: smc@ surrey.ac.uk

If you do decide to participate I would like to thank you very much for your highly valuable contribution to this research.

If you have any complaints about your participation in this research, in the first instance please contact the Chief Investigator, Claire Pond. The normal National Health Service complaints mechanisms should also be available to you. In the unlikely event of you suffering significant and enduring harm as a result of your participation in this research, the University of Surrey (as sponsor of the research) holds no-fault insurance cover which is intended to provide compensation to participants, regardless of liability. The University of Surrey also has public liability insurance, which covers public liability claims.
APPENDIX VI

DEMOGRAPHICS AND PREGNANCY QUESTIONNAIRE
DEMOGRAPHIC AND PREGNANCY QUESTIONNAIRE

It would be helpful if you could provide the following information about yourself and your experience of pregnancy and giving birth.

About you:

Your date of birth................................. Your age last birthday...........

What is your marital status?
[ ] married
[ ] civil partnership
[ ] living with partner
[ ] separated
[ ] divorced
[ ] single
[ ] widowed

Who do you live with?
[ ] husband/partner
[ ] husband/partner & children
[ ] your parents
[ ] friends
[ ] just your child(ren)
[ ] alone

Where do you live?
[ ] council rented home
[ ] own home
[ ] private rented home
[ ] hostel
[ ] bed & breakfast
education?
[ ] live in job

What educational qualifications do you have?
[ ] none
[ ] GNVQ foundation / other foundation / NVQ1
[ ] CSE / O level / GCSE / GNVQ intermediate / NVQ2
[ ] A levels / National Diploma / GNVQ Advanced / AVCE / NVQ3
[ ] Degree
[ ] Higher degree
[ ] Professional qualification (please specify) ........................................

Before the birth of your baby were you employed? [ ] unemployed? [ ] other? (please specify) [ ] ........................................

What job do you do, or if you are not currently working what was your last job?
Job title............................................ Type of business ................................

If you were working before the birth of your baby when did/will you return to work?..............................

If you have a partner, what is their occupation?
Job title........................................... Type of business ................................

please turn over
About your most recent experience of pregnancy and labour:

Baby's date of birth......How old is the baby now?........... Sex of baby/babies.................

How long did it take you to conceive? How did you conceive?
[ ] less than 3 months [ ] naturally
[ ] 3-12 months [ ] using an assisted reproduction technique (please specify which)
[ ] more than a year
[ ] had not been trying, pregnancy was a nice surprise
[ ] had not been trying, pregnancy was a bit of a shock

Did labour start naturally? [ ] or were you induced? [ ] At how many weeks gestation? ....

Method of delivery (please tick all that apply): Pain relief (please tick all that apply):
[ ] natural vaginal delivery [ ] none
[ ] elective caesarean [ ] TENS machine
[ ] emergency caesarean [ ] gas and air
[ ] assisted delivery - forceps [ ] pain relieving injection (i.e. pethidine)
[ ] assisted delivery - ventouse (vacuum extraction) [ ] epidural
[ ] other, please specify: [ ] other, please specify: ..............................

Who supported you during your labour? (please tick all that apply):
[ ] one midwife throughout
[ ] more than one midwife
[ ] partner
[ ] friend
[ ] relative, please specify: ..............................
[ ] other, please specify: ..............................

Compared to what you had expected, was your labour [ ] better [ ] the same [ ] worse

How much did the baby/babies weigh at birth? ....................

Following this labour, have you been referred to, or requested, midwife debriefing?
[ ] yes [ ] no

If you were referred, who made the referral? ....................

Was this your first pregnancy? [ ] yes [ ] no

If you have been pregnant before please answer the following question:

What was the outcome of your previous pregnancy/pregnancies?
[ ] abortion ................ how many?[ ]
[ ] miscarriage .......... how many?[ ]
[ ] still birth .......... how many?[ ]
[ ] live birth ........... how many?[ ]
(please provide date of birth and sex for each child)

date of birth ..................sex of child
date of birth .................. sex of child
date of birth .................. sex of child

If you have been in labour before, did you attend a midwife debriefing service?
[ ] yes [ ] no

If you have been in labour before, compared to your previous experience(s), was your most recent labour: [ ] better [ ] the same [ ] worse

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APPENDIX VII
THOUGHTS AND FEELINGS QUESTIONNAIRE
THOUGHTS AND FEELINGS QUESTIONNAIRE

Participant Identification Number:

Thank you for agreeing to complete this questionnaire. Some of these questions may not seem relevant to you but please try to answer all of them as best you can. When you get to the end please look back to check that you have answered all of the questions before returning the questionnaires in the stamped addressed envelope provided, along with your signed consent forms.

PART A

As you have recently had a baby we would like to know how you are feeling. Please underline the answer that comes closest to how you have felt in the past 7 days – not just how you feel today.

Here is an example, already completed:

I have felt happy:

Yes, all the time
Yes, most of the time
No, not very often
No, not at all

This would mean "I have felt happy most of the time during the past week"

In the past 7 days:

1. I have been able to laugh and see the funny side of things -

As much as I always could
Not quite so much now
Definitely not so much now
Not at all

2. I have looked forward with enjoyment to things –

As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

3. I have blamed myself unnecessarily when things went wrong –

Yes, most of the time
Yes, some of the time
Not very often
No, never
4. I have been anxious or worried for no good reason -
   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often

5. I have felt scared or panicky for no good reason -
   Yes, quite a lot
   Yes, sometimes
   No, not much
   No, not at all

6. Things have been getting on top of me -
   Yes, most of the time I haven't been able to cope at all
   Yes, sometimes I haven't been coping as well as usual
   No, most of the time I have coped quite well
   No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping –
   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all

8. I have felt sad or miserable -
   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all

9. I have been so unhappy that I have been crying –
   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, never

10. The thought of harming myself has occurred to me –
    Yes, quite often
    Sometimes
    Hardly ever
    Never
### PART B

Below are a few questions about your (most recent) experience of birth:

During your birth:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes [ ]</th>
<th>No [ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you sustain a physical injury?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did your baby sustain a physical injury?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you think that your life was in danger?</td>
<td></td>
<td></td>
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<tr>
<td>Did you think your baby’s life was in danger?</td>
<td></td>
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<tr>
<td>Did you feel helpless?</td>
<td></td>
<td></td>
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<tr>
<td>Did you feel terrified?</td>
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</tr>
</tbody>
</table>

Below is a list of problems that people sometimes have after (a traumatic) birth. Read each one carefully and circle the number (0-3) that best describes how often that problem bothered you in a typical MONTH after birth.

- 0 = not at all or only one time
- 1 = once a week or less / once in a while
- 2 = 2 or 4 times a week / half the time
- 3 = 5 or more times a week / almost always

<table>
<thead>
<tr>
<th>Problem</th>
<th>0 1 2 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having upsetting thoughts or images about the birth that came into your head when you didn’t want them to.</td>
<td></td>
</tr>
<tr>
<td>Having bad dreams or nightmares about the birth</td>
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<tr>
<td>Reliving the birth, acting or feeling as if it was happening again</td>
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<tr>
<td>Feeling emotionally upset when you were reminded of the birth (for example, feeling scared, angry, sad, guilty, etc.)</td>
<td></td>
</tr>
<tr>
<td>Experiencing physical reactions when you were reminded of the birth (for example, breaking out in a sweat, heart beating fast)</td>
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<tr>
<td>Trying not to think about, talk about, or have feelings about the birth</td>
<td></td>
</tr>
<tr>
<td>Trying to avoid activities, people, or places that remind you of the birth</td>
<td></td>
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<tr>
<td>Not being able to remember an important part of the birth</td>
<td></td>
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<tr>
<td>Having much less interest or participating much less often in important activities</td>
<td></td>
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<tr>
<td>Feeling distant or cut off from people around you</td>
<td></td>
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<tr>
<td>Feeling emotionally numb (for example, being unable to cry or unable to have loving feelings)</td>
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<tr>
<td>Feeling as if your future plans or hopes will not come true (for example, you will not have a career, marriage, children, or a long life)</td>
<td></td>
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<tr>
<td>Having trouble falling or staying asleep</td>
<td></td>
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<tr>
<td>Feeling irritable or having fits of anger</td>
<td></td>
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<tr>
<td>Having trouble concentrating (for example, drifting in and out of conversations, losing track of a story on television, forgetting what you read)</td>
<td></td>
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<tr>
<td>Being overly alert (for example, checking to see who is around you, being uncomfortable with your back to a door etc)</td>
<td></td>
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<tr>
<td>Being jumpy or easily startled (for example, when someone walks up behind you)</td>
<td></td>
</tr>
</tbody>
</table>

### PART C

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We are interested in the kind of thoughts which you may have had after giving birth, particularly about any traumatic aspects of the experience. Below are a number of statements that may or may not be representative of your thinking. Please read each statement carefully and tell us how much you AGREE or DISAGREE with each statement (by circling the number that best describes your thinking). People react to giving birth in many different ways. There are no right or wrong answers to these statements.

1 = totally disagree
2 = disagree very much
3 = disagree slightly
4 = neutral
5 = agree slightly
6 = agree very much
7 = totally agree

The event happened because of the way I acted
I can't trust that I will do the right thing
I am a weak person
I will not be able to control my anger and will do something terrible
I can't deal with even the slightest upset
I used to be a happy person but now I am always miserable
People can't be trusted
I have to be on guard all the time
I feel dead inside
You never know who will harm you
I have to be especially careful because you never know what can happen next
I am inadequate
I will not be able to control my emotions, and something terrible will happen
If I think about the event, I will not be able to handle it
The event happened to me because of the sort of person I am
My reactions since the event mean that I am going crazy
I will never be able to feel normal emotions again
The world is a dangerous place
Somebody else would have stopped the event from happening
I have permanently changed for the worse
I feel like an object, not like a person
Somebody else would not have gotten into this situation
I can't rely on other people
I feel isolated and set apart from others
I have no future
I can't stop bad things from happening to me
People are not what they seem
My life has been destroyed by the trauma
There is something wrong with me as a person
My reactions since the event show that I am a lousy coper
There is something about me that made the event happen
I will not be able to tolerate my thoughts about the event, and I will fall apart
I feel like I don't know myself anymore
You never know when something bad will happen
I can't rely on myself
Nothing good can happen to me anymore
Listed below are various people who may be important in your life. For each person please circle a number from 1 to 7 to show how well he or she provides the type of help that is listed. The second part of each question asks you to rate how you would like things to be if they were exactly as you hoped for. As before, please put a circle around one number between 1 and 7 to show what your rating is. Please note: if there is no such person in your life please leave that section blank and go on to the next section.

### Section 1 - Spouse (Husband/Wife) or Partner

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<tbody>
<tr>
<td>1 a</td>
<td>Can you trust, talk to frankly and share your feelings with your spouse/partner?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>1 b</td>
<td>What rating would your ideal be?</td>
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<tr>
<td>2 a</td>
<td>Can you lean on and turn to your spouse/partner in times of difficulty?</td>
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<tr>
<td>3 a</td>
<td>Does he/she give you practical help?</td>
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<tr>
<td>4 a</td>
<td>Can you spend time with him/her socially?</td>
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<td>2</td>
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### Section 2 - Mother

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<tbody>
<tr>
<td>1 a</td>
<td>Can you trust, talk to frankly and share your feelings with your mother?</td>
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<td>2 a</td>
<td>Can you lean on and turn to your mother in times of difficulty?</td>
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<td>3 a</td>
<td>Does she give you practical help?</td>
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<td>4 a</td>
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### Section 3 - Father

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<tbody>
<tr>
<td>1 a</td>
<td>Can you trust, talk to frankly and share your feelings with your father?</td>
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<td>4</td>
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<tr>
<td>3 a</td>
<td>Does he give you practical help?</td>
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<tr>
<td>4 a</td>
<td>Can you spend time with him socially?</td>
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</tbody>
</table>

**PLEASE CIRCLE ONE NUMBER ONLY FOR EACH QUESTION**
### Section 4 – Closest Brother or Sister

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 a Can you trust, talk to frankly and share your feelings with your brother/sister?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>1 b What rating would your ideal be?</td>
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<tr>
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<td>3 4 5 6 7</td>
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<td>3 4 5 6 7</td>
<td></td>
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<td>3 b What rating would your ideal be?</td>
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<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4 a Can you spend time with him/her socially?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
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</tbody>
</table>

### Section 5 – Other Brother or Sister

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 a Can you trust, talk to frankly and share your feelings with this brother/sister?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>1 b What rating would your ideal be?</td>
<td>1 2</td>
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<tr>
<td>2 a Can you lean on and turn to your brother/sister in times of difficulty?</td>
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<tr>
<td>4 a Can you spend time with him/her socially?</td>
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<td>3 4 5 6 7</td>
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<tr>
<td>4 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
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</tbody>
</table>

### Section 6 – Closest Son or Daughter

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 a Can you trust, talk to frankly and share your feelings with this son/daughter?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
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</tr>
<tr>
<td>1 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
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<td>3 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4 a Can you spend time with him/her socially?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

### Section 7 – Best Friend

<table>
<thead>
<tr>
<th>Question</th>
<th>Never</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 a Can you trust, talk to frankly and share your feelings with your best friend?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>1 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>2 a Can you lean on and turn to your best friend in times of difficulty?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>2 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>3 a Does he/she give you practical help?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>3 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4 a Can you spend time with him/her socially?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
<tr>
<td>4 b What rating would your ideal be?</td>
<td>1 2</td>
<td>3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

PLEASE CIRCLE ONE NUMBER ONLY FOR EACH QUESTION
APPENDIX VIII
OPEN ENDED QUESTIONS
Have your thoughts and feelings about your recent experience of giving birth changed since you completed the first questionnaire a month ago, and if so how?

Why do you think your thoughts and feelings have changed? Or if they have not changed why do you think this is?
APPENDIX XI
LETTER OF INVITATION
A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth.

I am contacting you because you have recently had a baby at (name of hospital) and am carrying out research into mother's psychological wellbeing after birth. I realise that time is precious when you are caring for a new baby, but I hope you will be able to find the time to read these documents and participate in this valuable research.

You are being invited to take part in research investigating the effect of midwife debriefing on mother's psychological wellbeing after birth. I am doing this by comparing the experience of women who have used midwife debriefing services with those who have not; the participation of women who have had midwife debriefing and those who have not is equally important.

The enclosed information sheet gives more details about the research and what taking part involves. If you decide to take part in the study please return the completed consent forms and questionnaires in the stamped addressed envelope enclosed, ideally within the next 10 days. If you decide not to take part please indicate this by returning the uncompleted papers in the same way so that I will know not to contact you again.

If you have any questions please contact me; you will find my contact details on the bottom of the information sheet.

If you do decide to help with this research I would like to thank you very much for your highly valuable contribution.

Yours sincerely

Claire Pond
Clinical Psychologist in Training
APPENDIX X

CONSENT FORM
Title of Project: A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth.

Name of Researcher: Claire Pond

1a I confirm that I have read and understand the information sheet dated dd/mm/yy (version xx) for the above study.

1b I have had the opportunity to consider the information and ask questions, and have had these answered satisfactorily.

2 I understand that my participation is voluntary and that I am free to withhold personal information or to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected.

3 I agree to take part in the above study.

4 I wish to receive a summary of the results of this research.

Please initial box

☐ Yes ☐ No ☐

Name of participant: Date Signature

Address of participant: Telephone number of participant:

Researcher: Date Signature

When completed please return both copies to the researcher who will also sign them. Then 1 copy is for participant and 1 copy for researcher.
APPENDIX XI
SHORT INFORMATION SHEET
My name is Claire Pond and I am a Trainee Clinical Psychologist from the University of Surrey. I am looking for participants for a study about the midwife debriefing service offered by this department. It is hoped that the study will enable the service to be evaluated and developed.

Women who have used the debriefing service will be contacted directly. I also need women who have not used the service to take part so I can compare their thoughts and feelings with those of women who have. Participation would involve you completing two questionnaires approximately one month apart. Each questionnaire should take 20-30 minutes.

If you agree you will be contacted by post when your baby is approximately 6 weeks old. You can decide at that time whether or not you want to participate. The decision you make will not affect the care you receive.

All data collected during the study will be kept strictly confidential in accordance with data protection laws and staff of this department will not have access to it.

If in the meantime you decide you would prefer not to be contacted please let me know, using the contact details below.

Claire Pond
Trainee Clinical Psychologist
Department of Psychology
University of Surrey
Guildford
GU2 7XH

Or you can leave a message for me on 01483 689 441
APPENDIX XII

COVERING LETTER FOR 'POST' QUESTIONNAIRE
A research study into the effect of midwife debriefing on the psychological wellbeing of women after birth.

Thank you very much for completing and returning the first questionnaire I sent you for the above study. Please find enclosed the final questionnaire; I would be grateful if you could complete this and return it in the prepaid envelope provided, ideally within the next 10 days. I realise that time is precious when you are caring for a new baby, but I hope you will be able to find the time to conclude your participation in this valuable research.

If you have any questions please contact me; you will find my contact details below.

The participation of women who have had midwife debriefing and those who have not is equally important.

I would like to thank you once again for your highly valuable contribution.

Yours sincerely

Contact details:
tel: 01483 689441
e-mail: psm1cd@surrey.ac.uk

Claire Pond
Clinical Psychologist in Training
c/o Department of Psychology
University of Surrey
Guildford, Surrey GU2 7XH

If you have requested a summary report of the research it would be helpful if I could send this to you by email. If you are happy to receive the report in this way please add your email address to the slip below, and return it with your final questionnaire.

Participant number: Email address:
APPENDIX XIII
COMPARISON OF DEMOGRAPHIC DATA
BY GROUP AND HOSPITAL
<table>
<thead>
<tr>
<th>Method of conception:</th>
<th>Debriefing Hospital A (n=15)</th>
<th>Debriefing Hospital B (n=23)</th>
<th>Total (n=38)</th>
<th>Comparison Hospital A (n=25)</th>
<th>Comparison Hospital B (n=34)</th>
<th>Total (n=60)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Assisted</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Time taken to conceive:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 3 months</td>
<td>52%</td>
<td>50%</td>
<td>51%</td>
<td>44%</td>
<td>42%</td>
<td>43%</td>
</tr>
<tr>
<td>3-12 months</td>
<td>14%</td>
<td>38%</td>
<td>26%</td>
<td>21%</td>
<td>42%</td>
<td>31%</td>
</tr>
<tr>
<td>&gt; 12 months</td>
<td>34%</td>
<td>9%</td>
<td>17%</td>
<td>15%</td>
<td>16%</td>
<td>15%</td>
</tr>
<tr>
<td>Unplanned – ‘nice surprise’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unplanned – ‘bit of a shock’</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weeks gestation:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>40 weeks and below</td>
<td>78%</td>
<td>28%</td>
<td>53%</td>
<td>71%</td>
<td>63%</td>
<td>67%</td>
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<tr>
<td>41 weeks and above</td>
<td>22%</td>
<td>72%</td>
<td>47%</td>
<td>29%</td>
<td>37%</td>
<td>33%</td>
</tr>
<tr>
<td>Labour start:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural</td>
<td>50%</td>
<td>8%</td>
<td>27%</td>
<td>39%</td>
<td>13%</td>
<td>26%</td>
</tr>
<tr>
<td>Induced</td>
<td>50%</td>
<td>92%</td>
<td>73%</td>
<td>61%</td>
<td>87%</td>
<td>74%</td>
</tr>
<tr>
<td>Pain relief:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>None</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>TENS</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Delivery:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Vaginal</td>
<td>46%</td>
<td>26%</td>
<td>36%</td>
<td>47%</td>
<td>24%</td>
<td>35%</td>
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<tr>
<td>Emergency caesarean</td>
<td>7%</td>
<td>25%</td>
<td>16%</td>
<td>7%</td>
<td>25%</td>
<td>16%</td>
</tr>
<tr>
<td>Not assisted – forceps</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Assisted – forceps &amp; ventouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
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</table>

Research Dossier: Major research project
APPENDIX XIV

COMPARISON OF PREGNANCY AND CHILDBIRTH DATA
BY GROUP AND HOSPITAL
## Demographic differences between groups by hospital

<table>
<thead>
<tr>
<th>Demographic Category</th>
<th>Debriefing Hospital A</th>
<th>Debriefing Hospital B</th>
<th>Debriefing Total</th>
<th>Comparison Hospital A</th>
<th>Comparison Hospital B</th>
<th>Comparison Total</th>
<th>Overall Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (years):</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SE)</td>
<td>34.33 (1.07)</td>
<td>32.25 (1.33)</td>
<td>33.61 (0.84)</td>
<td>30.62 (1.09)</td>
<td>30.17 (0.93)</td>
<td>30.36 (0.70)</td>
<td>31.25 (0.58)</td>
</tr>
<tr>
<td>Range</td>
<td>27-41</td>
<td>26-37</td>
<td>26-41</td>
<td>18-40</td>
<td>18-42</td>
<td>18-42</td>
<td>18-42</td>
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<td><strong>Cultural background:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>White British</td>
<td>93%</td>
<td>100%</td>
<td>95%</td>
<td>70%</td>
<td>73%</td>
<td>71%</td>
<td>78%</td>
</tr>
<tr>
<td>White Irish</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Any other White</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>30%</td>
<td>18%</td>
<td>23%</td>
<td>17%</td>
</tr>
<tr>
<td>Mixed White and Asian</td>
<td>7%</td>
<td>0%</td>
<td>5%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Asian or Asian British-Indian</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td><strong>Marital status:</strong></td>
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<tr>
<td>Married</td>
<td>53%</td>
<td>75%</td>
<td>61%</td>
<td>62%</td>
<td>77%</td>
<td>71%</td>
<td>68%</td>
</tr>
<tr>
<td>With partner</td>
<td>40%</td>
<td>25%</td>
<td>35%</td>
<td>31%</td>
<td>23%</td>
<td>26%</td>
<td>29%</td>
</tr>
<tr>
<td>Single</td>
<td>7%</td>
<td>0%</td>
<td>4%</td>
<td>8%</td>
<td>0%</td>
<td>3%</td>
<td>3%</td>
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<td><strong>Highest level of education:</strong></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>GCSE / Intermediate level and below</td>
<td>13%</td>
<td>25%</td>
<td>17%</td>
<td>23%</td>
<td>26%</td>
<td>25%</td>
<td>22%</td>
</tr>
<tr>
<td>'A' level / Advanced level</td>
<td>13%</td>
<td>0%</td>
<td>9%</td>
<td>35%</td>
<td>18%</td>
<td>25%</td>
<td>21%</td>
</tr>
<tr>
<td>Degree or higher</td>
<td>74%</td>
<td>75%</td>
<td>74%</td>
<td>42%</td>
<td>56%</td>
<td>50%</td>
<td>57%</td>
</tr>
<tr>
<td><strong>Occupation:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional / managerial / technical</td>
<td>33%</td>
<td>75%</td>
<td>48%</td>
<td>69%</td>
<td>59%</td>
<td>63%</td>
<td>59%</td>
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<tr>
<td>Skilled non-manual and manual</td>
<td>60%</td>
<td>13%</td>
<td>44%</td>
<td>23%</td>
<td>26%</td>
<td>25%</td>
<td>30%</td>
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<tr>
<td>Other</td>
<td>7%</td>
<td>12%</td>
<td>8%</td>
<td>8%</td>
<td>15%</td>
<td>12%</td>
<td>11%</td>
</tr>
<tr>
<td><strong>In paid employment before birth:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>80%</td>
<td>87%</td>
<td>83%</td>
<td>73%</td>
<td>77%</td>
<td>75%</td>
<td>77%</td>
</tr>
<tr>
<td>No</td>
<td>20%</td>
<td>13%</td>
<td>17%</td>
<td>27%</td>
<td>23%</td>
<td>25%</td>
<td>23%</td>
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<tr>
<td><strong>Home:</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rented</td>
<td>40%</td>
<td>25%</td>
<td>35%</td>
<td>31%</td>
<td>46%</td>
<td>39%</td>
<td>38%</td>
</tr>
<tr>
<td>Owned</td>
<td>60%</td>
<td>75%</td>
<td>65%</td>
<td>69%</td>
<td>54%</td>
<td>61%</td>
<td>62%</td>
</tr>
</tbody>
</table>
RESEARCH LOG CHECKLIST

Years 1 to 3
## Research Log Checklist

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and</td>
</tr>
<tr>
<td></td>
<td>literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues</td>
</tr>
<tr>
<td></td>
<td>of diversity, and structuring plans accordingly</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
</tr>
<tr>
<td>26</td>
<td>Presenting research findings in a variety of contexts</td>
</tr>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
</tr>
<tr>
<td></td>
<td>Research Dossier: Research log checklist</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
</tr>
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</table>